MedSleep

MedSleep Pembroke
Ottawa Valley Health and Wellness Centre
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SLEEP DISORDER REFERRAL FORM

Please fax this form to: 613-735-9301

PERSONAL INFORMATION

Name _____
PHN _____
Birth Date _____ Age _____
Height _____ Weight _____ Gender: ☐ M ☐ F

Home Phone _____
Work Phone _____
Street Address _____
City _____ Postal Code _____
Email _____

REFERRING PHYSICIAN

Physician _____
Billing # _____
Street Address _____
City _____ Postal Code _____

Phone _____
Fax _____
Email _____

HISTORY AND PHYSICAL INFORMATION

_____

_____

_____

☐ **ELECTIVE** ☐ **URGENT If urgent, please explain:**

_____

_____

❶ HISTORY OF SLEEP PROBLEM

☐ Snoring ☐ Nocturia ☐ Restless Legs Syndrome ☐ Cataplexy
☐ Witnessed Apneas ☐ Insomnia ☐ Periodic Limb Movement Disorder ☐ Sleepwalking/Nightmares
☐ Excessive Daytime Sleepiness ☐ Frequent Awakenings ☐ Shift Work ☐ Other _____

❷ MEDICAL CONDITIONS

☐ MI/CAD ☐ Seizures/Epilepsy ☐ GERD ☐ Fibromyalgia ☐ Mood Disorder ☐ Anxiety Disorder ☐ Hypertension
☐ Diabetes ☐ Stroke ☐ Asthma/COPD ☐ Chronic Pain ☐ CHF ☐ Cardiac Arrhythmia

❸ MEDICATIONS

_____

_____

❹ DOES THE PATIENT HAVE A SAFETY CRITICAL OCCUPATION? ☐ Yes ☐ No

➕ SPECIAL NEEDS *(i.e., assistance moving, difficulty communicating)*

_____

_____

Physician's signature: _____ Date: _____

☐ *PLEASE CHECK IF YOU WOULD LIKE US TO SEND YOU MORE REFERRAL FORMS.*