**MedSleep Prince George**
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MedSleep

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# SLEEP DISORDER REFERRAL FORM

## Please fax this form to: (250) 596-1875

### 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:**

_____

_____

**1 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 _____ |

**2 MEDICAL CONDITIONS**

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

**3 MEDICATIONS**

_____

_____

**4 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.*