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SLEEP DISORDER REFERRAL FORM
Please fax this form to: 778-379-4811

LOCATION: MedSleep Vancouver MedSleep Burnaby MedSleep Maple Ridge

PLEASE CHOOSE ONE OF:

- REQUEST FOR CONSULTATION**
- APNEA FAST TRACK™**
In-home sleep study followed by APAP therapy for Obstructive Sleep Apnea (OSA) and/or Sleep Medicine Consultation (as indicated)
- IN-HOME SLEEP STUDY FOR OSA**
Sleep Medicine Consultation (as indicated)
- IN-CLINIC LEVEL 1 (FULL POLYSOMNOGRAPHIC) SLEEP STUDY** *(Covered by MSP)*
at Nanaimo Sleep Clinic
Sleep Consultation to follow at MedSleep Vancouver

PATIENT INFORMATION

Name _____
 PHN _____
 Home Phone _____
 Work Phone _____
 Cell Phone _____
 Date of birth _____ Age _____
 Height _____ Weight _____ Gender M F
 Address _____
 City _____ Postal Code _____
 Email _____

HISTORY OF SLEEP PROBLEMS

- | | |
|---|--|
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Witnessed Apneas | <input type="checkbox"/> Frequent Awakenings |
| <input type="checkbox"/> Excessive Daytime Sleepiness | <input type="checkbox"/> Sleepwalking/Confusional Arousal |
| <input type="checkbox"/> Cataplexy | <input type="checkbox"/> Shift Work |
| <input type="checkbox"/> Restless Legs Syndrome | <input type="checkbox"/> Past Sleep Study <i>(please send)</i> |
| <input type="checkbox"/> Periodic Limb Movements | <input type="checkbox"/> Other _____ |

REFERRING PHYSICIAN

Physician Name _____
 Phone _____
 Fax _____
 Billing # _____
 Address _____
 City _____ Postal Code _____
 Clinic Email _____

MEDICAL CONDITIONS

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> MI/CAD | <input type="checkbox"/> Hypertension | <input type="checkbox"/> GERD |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Mood Disorder | <input type="checkbox"/> Anxiety Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Asthma/COPD |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> CHF | <input type="checkbox"/> Cardiac Arrhythmia |

HISTORY AND PHYSICAL INFORMATION

MEDICATIONS

PHYSICAL FINDINGS *(Such as mallampati score)*

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

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