MedSleep

MedSleep Vancouver

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SLEEP DISORDER REFERRAL FORM

Please fax this form to: 778-379-4811

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 _____
Date of birth _____ Age _____
Height _____ Weight _____ Gender ☐ M ☐ F
Address _____
City _____ Postal Code _____
Email _____

HISTORY OF SLEEP PROBLEMS

☐ Snoring
☐ Witnessed Apneas
☐ Excessive Daytime Sleepiness
☐ Cataplexy
☐ Restless Legs Syndrome
☐ Periodic Limb Movements
☐ Insomnia
☐ Frequent Awakenings
☐ Sleepwalking/Confusional Arousal
☐ Shift Work
☐ Past Sleep Study (*please send*)
☐ Other _____

REFERRING PHYSICIAN

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

MEDICAL CONDITIONS

☐ MI/CAD
☐ Fibromyalgia
☐ Diabetes
☐ Chronic Pain
☐ Hypertension
☐ Mood Disorder
☐ Stroke
☐ CHF
☐ GERD
☐ Anxiety Disorder
☐ Asthma/COPD
☐ 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.*