MedSleep

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PROFESSIONAL EXPERTISE • COMPREHENSIVE EVALUATION • INTEGRATIVE TREATMENT

SLEEP DISORDER REFERRAL FORM

Please fax this form to: 250-391-8400

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 Victoria

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

- ☐ 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.*