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Med*Sleep*

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SLEEP DISORDER REFERRAL FORM

PLEASE FAX THIS FORM TO: (250) 758-0063

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

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

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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.*