MedSleep NSC

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# SLEEP DISORDER REFERRAL FORM

**PLEASE FAX THIS FORM TO: 1-888-905-6992**

## PERSONAL INFORMATION

Name _____
OHIP Number _____
Birth Date _____ Age _____

Height _____ Weight _____ Gender: ☐ M ☐ F
Home Phone _____
Work Phone _____
Email _____

## REFERRING PHYSICIAN

Physician _____
Billing # _____
Street Address _____
City _____ Zip/Postal Code _____

Phone _____
Fax _____
Email _____

## REFERRAL FOR

☐ **SLEEP STUDY ONLY** (*Please complete sections 1–5 below*) *OR* ☐ **CONSULTATION AND SLEEP STUDY, IF INDICATED** (*Please complete sections 1–3 below*)

- *Has the referred patient had a previous sleep study?* ☐ *Yes* ☐ *No*
- *If yes, please provide the date of the last sleep study:* _____ *Location:* _____

## HISTORY AND PHYSICAL INFORMATION

_____

_____

### ❶ HISTORY OF SLEEP PROBLEM

☐ Snoring
☐ Witnessed Apneas
☐ Excessive Daytime Sleepiness
☐ Nocturia
☐ Insomnia
☐ Frequent Awakenings
☐ Restless Legs Syndrome
☐ Periodic Limb Movement Disorder
☐ Shift Work
☐ Cataplexy
☐ Sleepwalking/Nightmares
☐ 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 RELEVANT FAMILY / SOCIAL / PERSONAL HISTORY *(if request for sleep study only)*

_____

### ❺ PHYSICAL EXAM – POSITIVE FINDINGS *(if request for sleep study only)*

_____

### ❻ 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.*

*FOR CLINIC USE ONLY: DATE:_____ STAT / ROUTINE PSG / P / R / NR / PED / OTHER:_____*