

SLEEP DISORDER REFERRAL FORM

- TORONTO LOCATION** 586 Eglinton Avenue East, Suite 507 Toronto, Ontario, Canada M4P 1P2 Phone: 416-488-6980 Fax: 416-488-3998
 THORNHILL LOCATION 390 Steeles Avenue West, Suite 208 Thornhill, Ontario, Canada L4J 6X2 Phone: 905-709-9696 Fax: 905-709-9764

PERSONAL INFORMATION

Name _____ Height _____ Weight _____ Gender: M F
 OHIP Number _____ Home Phone _____
 Birth Date _____ Age _____ Work Phone _____
 Email _____

REFERRING PHYSICIAN

Physician _____ Phone _____
 Billing # _____ Fax _____
 Street Address _____ Email _____
 City _____ Zip/Postal Code _____

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

1 HISTORY OF SLEEP PROBLEM

- | | | |
|---|--|--|
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Shift Work |
| <input type="checkbox"/> Witnessed Apneas | <input type="checkbox"/> Frequent Awakenings | <input type="checkbox"/> Cataplexy |
| <input type="checkbox"/> Excessive Daytime Sleepiness | <input type="checkbox"/> Restless Legs Syndrome | <input type="checkbox"/> Sleepwalking/Nightmares |
| <input type="checkbox"/> Nocturia | <input type="checkbox"/> Periodic Limb Movement Disorder | <input type="checkbox"/> Other _____ |

2 MEDICAL CONDITIONS

- | | | | | | | |
|-----------------------------------|--|--------------------------------------|---------------------------------------|--|---|---------------------------------------|
| <input type="checkbox"/> MI/CAD | <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> GERD | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Mood Disorder | <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Hypertension |
| <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 | |

3 MEDICATIONS

4 RELEVANT FAMILY / SOCIAL / PERSONAL HISTORY (if request for sleep study only)

5 PHYSICAL EXAM – POSITIVE FINDINGS (if request for sleep study only)

+ 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: _____