

IMPROVING HEALTH THROUGH BETTER SLEEP • ACROSS CANADA*MedSleep clinics provide clinical consultation, diagnostic services (sleep testing) and treatment for the full spectrum of sleep disorders*

SLEEP DISORDER REFERRAL FORM

Please fax this form to: 250-596-1875**PLEASE CHOOSE ONE OF:**

APNEA FAST TRACK™
*In-home sleep study followed by APAP therapy
for Obstructive Sleep Apnea (OSA) and/or
Sleep Medicine Consultation (as indicated)*

REQUEST FOR CONSULTATION

**IN-CLINIC LEVEL 1
(FULL POLYSOMNOGRAPHIC)
SLEEP STUDY** *(Covered by MSP)*
Sleep Consultation performed prior to testing

IN-HOME (LEVEL 3) SLEEP STUDY FOR OSA
Sleep Medicine Consultation (as indicated)

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

- | | |
|---|--|
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Witnessed Apneas | <input type="checkbox"/> Frequent Awakenings |
| <input type="checkbox"/> Excessive Daytime Sleepiness | <input type="checkbox"/> Sleepwalking/Confusional Arousal |
| <input type="checkbox"/> Cataplexy | <input type="checkbox"/> Shift Work |
| <input type="checkbox"/> Restless Legs Syndrome | <input type="checkbox"/> Past Sleep Study <i>(please send)</i> |
| <input type="checkbox"/> Periodic Limb Movements | <input type="checkbox"/> Other _____ |

REFERRING PHYSICIAN

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

MEDICAL CONDITIONS

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

HISTORY AND PHYSICAL INFORMATION

 Elective Urgent

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.