MedSleep

Northern Alberta Sleep Clinic

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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: 780-487-3045

LOCATION: ☐ Edmonton West ☐ Edmonton South

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

☐ **IN-CLINIC LEVEL 1 (FULL POLYSOMNOGRAPHIC) SLEEP STUDY** *(not covered by AHC)*

☐ **IN-HOME SLEEP STUDY FOR OSA AND CONSULTATION**

☐ **REQUEST FOR CONSULTATION**
Sleep medicine Consultation and Sleep Testing (as indicated)

PATIENT INFORMATION

Name _____
AHCIP Number _____
Home Phone _____
Work Phone _____
Date of birth _____ Age _____
Height _____ Weight _____ Gender: ☐ M ☐ F
Address _____
City _____ Postal Code _____
Email _____

HISTORY OF SLEEP PROBLEMS

☐ Snoring
☐ Restless Legs Syndrome
☐ Witnessed Apneas
☐ Shift Work
☐ Excessive Daytime Sleepiness
☐ Sleepwalking/Nightmares
☐ Cataplexy
☐ Insomnia
☐ Periodic Limb Movements
☐ Frequent Awakenings
☐ Past sleep study (please send)
☐ Other _____

REFERRING PHYSICIAN

Physician Name _____
Phone _____
Fax _____
PRACID # _____
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)*

_____
_____

Physician's signature: _____ Date: _____

☐ *PLEASE CHECK IF YOU WOULD LIKE US TO SEND YOU MORE REFERRAL FORMS.*