Vancouver 506 - 1755 West Broadway • Vancouver BC V6J 4S5
Burnaby 4645 Kingsway • Burnaby BC V5H 2B3
Maple Ridge 110-20528 Lougheed Hwy • Maple Ridge BC V2X 2P8
North Vancouver 108-845 Marine Drive • North Vancouver BC V7P 0A8

Phone: 778-379-3844 • Fax: 778-379-4811 • vancouver@medsleep.com • www.medsleep.com

SLEEP DISORDER REFERRAL FORM

Please fax this form to: 778-379-4811

LOCATION: ☐ MedSleep Vancouver ☐ MedSleep Burnaby ☐ MedSleep Maple Ridge ☐ MedSleep North Vancouver

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**
Level 1 (Full Polysomnogram) to follow as needed and performed at Nanaimo Sleep Clinic

☐ **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

☐ Snoring
☐ Witnessed Apneas
☐ Excessive Daytime Sleepiness
☐ Cataplexy
☐ Restless Legs Syndrome
☐ Periodic Limb Movements
☐ Insomnia
☐ Frequent Awakenings
☐ Sleepwalking/Confusional Arousal
☐ Shift Work
☐ Past Sleep Study (*please send*)
☐ Other ______________

REFERRING PHYSICIAN

Physician Name ______________________
Phone ______________________
Fax ______________________
Billing # ______________________
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)*

____
____

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