MedSleep

torontosleepinstitute
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SLEEP DISORDER REFERRAL FORM

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

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:_____