

**SLEEP DISORDER REFERRAL FORM PLEASE FAX THIS FORM TO: 613-547-9910****PERSONAL INFORMATION**

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
OHIP # \_\_\_\_\_ Street Address \_\_\_\_\_  
Birth Date \_\_\_\_\_ Age \_\_\_\_\_ City \_\_\_\_\_ Postal Code \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_ Gender:  M  F Email \_\_\_\_\_

**REFERRING PRACTITIONER**

Physician/NP \_\_\_\_\_ Phone \_\_\_\_\_  
Billing # \_\_\_\_\_ Fax \_\_\_\_\_  
Street Address \_\_\_\_\_ Email \_\_\_\_\_  
City \_\_\_\_\_ 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**

**ELECTIVE**  **URGENT** If urgent, please explain: \_\_\_\_\_

**① HISTORY OF SLEEP PROBLEM**

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Snoring                      | <input type="checkbox"/> Nocturia            | <input type="checkbox"/> Restless Legs Syndrome          | <input type="checkbox"/> Cataplexy               |
| <input type="checkbox"/> Witnessed Apneas             | <input type="checkbox"/> Insomnia            | <input type="checkbox"/> Periodic Limb Movement Disorder | <input type="checkbox"/> Sleepwalking/Nightmares |
| <input type="checkbox"/> Excessive Daytime Sleepiness | <input type="checkbox"/> Frequent Awakenings | <input type="checkbox"/> Shift Work                      | <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 DOES THE PATIENT HAVE A SAFETY CRITICAL OCCUPATION?**

Yes  No

**⑤ SPECIAL NEEDS (i.e., assistance moving, difficulty communicating)**

Physician/NP signature: \_\_\_\_\_ Date: \_\_\_\_\_

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