

PEDIATRIC REFERRAL FORM

PLEASE NOTE, WE ARE UNABLE TO ACCEPT THE FOLLOWING REFERRALS AT PRESENT:

- All patients < 4y
- Patients < 13y with the following presentations: Suspected RLS, suspected narcolepsy/hypersomnia, complex parasomnias (associated with self-injurious behaviours and/or suspected nocturnal seizure), craniofacial abnormalities, neuromuscular disease, complex neurological conditions

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 _____ Postal Code _____
Phone _____ Fax _____
Email _____

REFERRAL FOR

- CONSULTATION & SLEEP STUDY, IF INDICATED**
 SLEEP STUDY ONLY (option available if referring MD is a pediatric ENT, sleep physician, or respirologist)

REASON FOR CONSULTATION

- Snoring Difficulty initiating sleep
 Witnessed apneas Difficulty staying asleep
 Circadian concern
 Fatigue
 Excessive daytime sleepiness
Epworth Sleepiness Scale score (if available) _____
 Parasomnia behaviours (sleep terrors/confusional arousals/sleepwalking)
 Restless leg syndrome or periodic limb movements
 Other _____

MEDICATIONS

RELEVANT INVESTIGATIONS/PHYSICAL FINDINGS

SPECIAL NEEDS

MEDICAL HISTORY Obesity with BMI > 35

PSYCHIATRIC HISTORY

COMMENTS

PHYSICIAN'S SIGNATURE

DATE

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

FOR OFFICE: PED-R PED-P CBT-I PED-NP TRIAGE TO ANOTHER CENTRE