MedSleep

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

PERSONAL INFORMATION

Name ______________________ Home Phone ______________ Work Phone ______________

OHIP # ______________ VC ________ 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

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☐ **ELECTIVE** ☐ **URGENT** If urgent, please explain: ______________________

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❶ HISTORY OF SLEEP PROBLEM

☐ Snoring ☐ Nocturia ☐ Restless Legs Syndrome ☐ Cataplexy

☐ Witnessed Apneas ☐ Insomnia ☐ Periodic Limb Movement Disorder ☐ Sleepwalking/Nightmares

☐ Excessive Daytime Sleepiness ☐ Frequent Awakenings ☐ Shift Work ☐ 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

____

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❹ DOES THE PATIENT HAVE A SAFETY CRITICAL OCCUPATION?

☐ Yes ☐ No

❺ 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.*