MedSleep

MedSleep Pembroke
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SLEEP DISORDER REFERRAL FORM *PLEASE FAX THIS FORM TO: 613-735-9301*

PERSONAL INFORMATION

Name _____
OHIP # _____ VC _____
Birth Date _____ Age _____
Height _____ Weight _____ Gender: ☐ M ☐ F

Home Phone _____ Work Phone _____
Street Address _____
City _____ Postal Code _____
Email _____

REFERRING PRACTITIONER

Physician/NP _____
Billing # _____
Street Address _____
City _____ 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

_____

_____

_____

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

_____

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

_____

_____

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.*