

IMPROVING HEALTH THROUGH BETTER SLEEP • ACROSS CANADA*MedSleep clinics provide clinical consultation, diagnostic services (sleep testing) and treatment for the full spectrum of sleep disorders*

SLEEP DISORDER REFERRAL FORM

PLEASE FAX THIS FORM TO: 1-905-456-8768

PERSONAL INFORMATIONName _____
OHIP Number _____ VC _____
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.
- OR **SLEEP STUDY WITH CONSULTATION, IF ABNORMAL**

HAS THE REFERRED PATIENT HAD A PREVIOUS SLEEP STUDY? NO YES**IF YES, PLEASE PROVIDE:**

DATE of last sleep study _____

LOCATION _____

HISTORY AND PHYSICAL INFORMATION**1 HISTORY OF SLEEP PROBLEM**

- | | | |
|---|--|--|
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Shift Work |
| <input type="checkbox"/> Witnessed Apneas | <input type="checkbox"/> Frequent Awakenings | <input type="checkbox"/> Cataplexy |
| <input type="checkbox"/> Excessive Daytime Sleepiness | <input type="checkbox"/> Restless Legs Syndrome | <input type="checkbox"/> Sleepwalking/Nightmares |
| <input type="checkbox"/> Nocturia | <input type="checkbox"/> Periodic Limb Movement Disorder | <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 RELEVANT FAMILY / SOCIAL / PERSONAL HISTORY (if request for sleep study only)****5 PHYSICAL EXAM – POSITIVE FINDINGS (if request for sleep study only)****+ 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: _____