

Sleep Disorder Referral Form

PATIENT INFORMATION

NAME _____

DATE OF BIRTH (D/M/Y) _____

PHONE # _____

HEALTH CARD # _____

DIAGNOSTIC TEST REQUESTED

PLEASE SELECT ONE OF THE BELOW:

- APNEA FAST TRACK™ (IN HOME) LEVEL 3 SLEEP STUDY with interpretation**
followed by APAP therapy and/or Sleep Medicine consultation as indicated or recommended
- SLEEP MEDICINE CONSULTATION** *Physician consultation and sleep testing as indicated*
- LEVEL 3 SLEEP STUDY (In home) Diagnostic Study only**
- RE-ASSESS PAP THERAPY AND SETTINGS** *already diagnosed with Sleep Apnea and currently using PAP therapy*

SYMPTOMS and /or MEDICAL CONDITIONS

SYMPTOMS:

- Snoring
- Insomnia
- Witnessed Apneas
- Excessive Daytime Fatigue
- Excessive Daytime Sleepiness
- Restless Legs Syndrome
- Other _____

MEDICAL CONDITIONS:

- MI/CAD
- Seizures/Epilepsy
- GERD
- Fibromyalgia
- Mood Disorder
- Anxiety Disorder
- Hypertension
- Diabetes
- Stroke
- Asthma/COPD
- Chronic Pain
- CHF
- Cardiac Arrhythmia
- Other _____

COMMENTS / MEDICATIONS:

PHYSICIAN and CLINIC INFORMATION

PHYSICIAN OR NP NAME _____

BILLING NUMBER [OPTIONAL] _____

STREET ADDRESS _____

CITY _____

POSTAL CODE _____

PHONE NUMBER _____

FAX NUMBER _____

DATE _____

OFFICE STAMP

SIGNATURE _____

PLEASE FAX TO 902-407-4341**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*