MedSleep Alberta

Accredited by the College of Physicians and Surgeons of Alberta

SLEEP DISORDER REFERRAL FORM

LOCATION: ☐ **CALGARY** ☐ **EDMONTON – WEST** ☐ **EDMONTON – SOUTH**

Phone: 403-254-6400 • Fax: 403-254-6403 **Phone: 780-487-5333 • Fax: 780-487-3045**

PLEASE CHOOSE ONE OF:

☐ **APNEA FAST TRACK**™
In-home sleep study followed by APAP therapy for Obstructive Sleep Apnea (OSA) and/or Sleep Medicine consultation as indicated

☐ **IN-CLINIC LEVEL 1 (FULL POLYSOMNOGRAPHIC) SLEEP STUDY** *(not covered by AHC)*
☐ STAT REPORT

☐ **IN-HOME SLEEP STUDY FOR OSA**
☐ STAT REPORT

☐ **REQUEST FOR CONSULTATION**
Sleep medicine Consultation and Sleep Testing (as indicated)

HISTORY OF SLEEP PROBLEMS

☐ Snoring
☐ Restless Legs Syndrome
☐ Witnessed Apneas
☐ Shift Work
☐ Excessive Daytime Sleepiness
☐ Sleepwalking/Nightmares
☐ Cataplexy
☐ Insomnia
☐ Periodic Limb Movements
☐ Frequent Awakenings
☐ Past sleep study (please send)
☐ Other _____

MEDICAL CONDITIONS

☐ MI/CAD
☐ Fibromyalgia
☐ Diabetes
☐ Chronic Pain
☐ Hypertension
☐ Mood Disorder
☐ Stroke
☐ CHF
☐ GERD
☐ Anxiety Disorder
☐ Asthma/COPD
☐ Cardiac Arrhythmia

MEDICATIONS

PHYSICAL FINDINGS *(Such as mallampati score)*

SPECIAL NEEDS *(i.e. assistance moving, difficulty communicating)*

PATIENT INFORMATION

Name _____
AHCIP Number _____
Home Phone _____
Work Phone _____
Date of birth _____ Age _____
Height _____ Weight _____ Gender: ☐ M ☐ F
Address _____
City _____ Postal Code _____
Email _____

REFERRING PHYSICIAN

Physician Name _____
Phone _____
Fax _____
PRACID # _____
Address _____
City _____ Postal Code _____
Clinic Email _____

HISTORY AND PHYSICAL INFORMATION

Physician's signature: _____ Date: _____

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