MedSleep

Niagara Snoring & Sleep Centre
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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: 1-888-905-6992

PERSONAL INFORMATION

Name _____
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*)

1. *Has the referred patient had a previous sleep study?* ☐ *Yes* ☐ *No*
2. *If yes, please provide the date of the last sleep study:* _____ *Location:* _____

HISTORY AND PHYSICAL INFORMATION

❶ HISTORY OF SLEEP PROBLEM

☐ Snoring
☐ Witnessed Apneas
☐ Excessive Daytime Sleepiness
☐ Nocturia
☐ Insomnia
☐ Frequent Awakenings
☐ Restless Legs Syndrome
☐ Periodic Limb Movement Disorder
☐ Shift Work
☐ Cataplexy
☐ Sleepwalking/Nightmares
☐ 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 RELEVANT FAMILY / SOCIAL / PERSONAL HISTORY *(if request for sleep study only)*

❺ 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:_____