

## 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**