MedSleep

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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

11 Jan 2022 v20

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