



**VANCOUVER ISLAND • NORTHERN BC • INTERIOR BC
GREATER VANCOUVER AREA**

General Phone: 1-877-855-7431 • General Fax: 1-844-652-7386
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PLEASE CHOOSE ONE OF:

- CONSULTATION AND LEVEL 1 POLYSOMNOGRAM (as appropriate)
- HOME SLEEP APNEA TESTING
MUST include BC Ministry of Health Form A: Requisition for Home Sleep Apnea Test (HSAT)

REASON FOR REFFERAL

- Snoring
- Insomnia
- Witnessed Apneas
- Frequent Awakenings
- Excessive Daytime Sleepiness
- Sleepwalking/Confusional Arousal
- Cataplexy
- Shift Work
- Restless Legs Syndrome
- Past Sleep Study (please send)
- Periodic Limb Movements
- Other _____

MEDICAL CONDITIONS

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

LOCATION:

- Burnaby**
- Campbell River*
- Langford**
- Nanaimo*
- Penticton*
- Prince George*
- Saanich **

*These clinics offer Level 1 and HSAT services **These clinics offer HSAT services

PATIENT INFORMATION

Name _____

PHN _____

Primary Phone _____

Secondary Phone _____

Date of Birth (mm/dd/yy) _____ Age _____

Height _____ Weight _____

Gender M F Other (describe/list pronouns) _____

Address _____

City _____ Postal Code _____

Email _____

REFERRING CARE PROVIDER

Name _____ MD NP

Phone _____ Fax _____

Billing # _____

Address _____

City _____ Postal Code _____

HISTORY AND PHYSICAL INFORMATION

MEDICATIONS

Care Provider's signature _____ Date _____

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