MedSleep

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SLEEP DISORDER REFERRAL FORM

PLEASE FAX THIS FORM TO: 905-203-2882

PERSONAL INFORMATION

Name _____ Height _____ Weight _____ Gender: ☐ M ☐ F

OHIP Number _____ VC _____ Preferred Contact Phone _____

Birth Date _____ Age _____ Email _____

REFERRING PHYSICIAN

Physician _____ Street Address _____

Billing # _____ City _____ Zip/Postal Code _____

PLEASE CHECK applicable practice model so you will not be negated: Phone _____ Fax _____

▶ ☐ **FHT** ☐ **FHO** ☐ **FHG** ☐ **FHN** ☐ **FFS** ☐ **HSO** 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*)

- *Has the referred patient had a previous sleep study?* ☐ *Yes* ☐ *No*
- *If yes, please provide the date of the last sleep study:* _____ *Location:* _____
- *Please provide the most recent sleep study report if it was done at another facility*

HISTORY AND PHYSICAL INFORMATION

❶ HISTORY OF SLEEP PROBLEM

☐ Snoring ☐ Insomnia ☐ Shift Work
☐ Witnessed Apneas ☐ Frequent Awakenings ☐ Cataplexy
☐ Excessive Daytime Sleepiness ☐ Restless Legs Syndrome ☐ Sleepwalking/Nightmares
☐ Nocturia ☐ Periodic Limb Movement Disorder ☐ 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)*

❻ 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:_____