Self Referral Request

MedSleep Alberta

Accredited by the College of Physicians and Surgeons of Alberta

SLEEP DISORDER REFERRAL FORM

LOCATION: ☐ CALGARY ☐ EDMONTON – WEST ☐ EDMONTON – SOUTH

Phone: 403-254-6400 • Fax: 403-254-6403 (Calgary)

Phone: 780-487-5333 • Fax: 780-487-3045 (Edmonton)

PLEASE CHOOSE ONE OF:

☐ **APNEA FAST TRACK™**
In-home sleep study followed by APAP therapy for Obstructive Sleep Apnea (OSA) and/or Sleep Medicine consultation as indicated

☐ **IN-CLINIC LEVEL 1 (FULL POLYSOMNOGRAPHIC) SLEEP STUDY** *(not covered by AHC)*
☐ STAT REPORT

☐ **IN-HOME SLEEP STUDY FOR OSA**
☐ STAT REPORT

☐ **REQUEST FOR CONSULTATION**
Sleep medicine Consultation and Sleep Testing (as indicated)

HISTORY OF SLEEP PROBLEMS

☐ Snoring	☐ Cataplexy
☐ Restless Legs Syndrome	☐ Insomnia
☐ Witnessed Apneas	☐ Periodic Limb Movements
☐ Shift Work	☐ Frequent Awakenings
☐ Excessive Daytime Sleepiness	☐ Past sleep study (please send)
☐ Sleepwalking/Nightmares	☐ Other _

MEDICAL CONDITIONS

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

MEDICATIONS

PHYSICAL FINDINGS *(Such as mallampati score)*

SPECIAL NEEDS *(i.e. assistance moving, difficulty communicating)*

PATIENT INFORMATION

Name ______________________

AHCIP Number ______________________

Home Phone ______________________

Work Phone ______________________

Date of birth ______________________ Age __________

Height ________ Weight __________ Gender:

Address ______________________

City ______________ Postal Code __________

Email ______________________

REFERRING PHYSICIAN

Physician Name ______________________

Phone ______________________

Fax ______________________

PRACID # ______________________

Address ______________________

City ______________ Postal Code __________

Clinic Email ______________________

HISTORY AND PHYSICAL INFORMATION

Physician's signature: ______________________ Date: ______________________

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

Sleep Disorder Quiz

Symptoms & Medical History

☐ Snoring

☐ Awakening during sleep: gasping, choking, and/or racing heart

☐ Difficulty falling asleep

☐ Difficulty staying asleep

☐ Tired during the day

☐ Leg discomfort that prevents me from falling asleep

☐ Unusual behavior during sleep

☐ Frequent, disturbing nightmares

☐ Other: ____

Please tell us a little about your Medical History

☐ High Blood Pressure or taking high blood pressure medication

☐ High cholesterol

☐ Diabetes

☐ Past heart attack

☐ Atrial fibrillation

☐ Stroke

☐ Chronic Pain

☐ Lung Disease

☐ Depression / Anxiety

☐ Tonsils removed

Previous sleep studies? ☐Y ☐N Where/When completed: ___________________________

Previous CPAP Trial for sleep anea? ☐Y ☐N Where/When completed: ________________

Your Sleep Schedule

- How long does it take you to fall asleep?

☐ Less than 30min ☐ 30-60 min ☐ More than 60min

- How often do you wake up during the night?

☐ None ☐ Once ☐ Twice ☐ More than twice

- Do you have problems falling back asleep after waking up? ☐ Y ☐ N
- How many hours of sleep do you usually get per night? ____________________________
- Do you take anything to help you sleep? ☐ Y ☐ N ________________________________

Please tell us about your usual Daytime Function

☐ Full of energy

☐ Tired in the morning but well during the day

☐ Moderate energy for important and other activities

☐ Low energy, enough for important activities and some other activities

☐ No energy, struggle to complete important activities and often take long naps

Other Symptoms

☐ I am often worried, anxious, planning/problem solving before bed

☐ I often toss and turn at night

☐ I frequently have a headache when I wake up

☐ I wake up to use the washroom more than once per night

☐ I 've been told I stop breathing at night

☐ I talk/walk/act out my dreams in my sleep

☐ I feel I could fall asleep anywhere

Health Care

☐ Alberta Health Care ☐ Alberta Works ☐ Indigenous Affairs

☐ Veterans Affairs ☐ AISH ☐ Other: ____