MedSleep

VANCOUVER ISLAND • NORTHERN BC • INTERIOR BC
GREATER VANCOUVER AREA

General Phone: 1-877-855-7431 · **General Fax:** 1-844-652-7386
General Email: bc@medsleep.com · www.medsleep.com

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:

☐ Campbell River*
☐ Coquitlam*
☐ 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.