MedSleep

☐ Carleton Place Sleep Clinic	Fax: 343-763-2048
☐ Kingston – Limestone City Sleep Lab	Fax: 613-547-9910
☐ MedSleep Napanee	Fax: 343-893-2267
☐ MedSleep Pembroke	Fax: 613-735-9301
☐ MedSleep Perth	Fax: 343-341-5560
☐ West Ottawa Sleep Centre	Fax: 613-722-9100

REASON FOR REFFERAL

☐ Snoring/Sleep Apnea
☐ New PAP Device
☐ Excessive Daytime Sleepiness
☐ Frequent Awakenings
☐ Narcolepsy/Cataplexy
☐ Sleep Behaviour Disorder
(shouting/kicking/walking/sex/talking)
☐ Restless Legs Syndrome
☐ Sleep Schedule Disorder
☐ Sleep Initiation Insomnia
☐ Pre-Operative Assessment
☐ Other _____

_____

REVELVANT MEDICAL HISTORY

(attach CPP with Medication List)

☐ CAD / CHF / Cardiac Arrhythmia
☐ Stroke / TIA
☐ COPD ☐ O2 Use
☐ Resistant Hypertension
☐ Current Pregnancy
☐ Sleep Apnea
Currently Adherent to therapy?
☐ Yes ☐ No
☐ Previous Sleep Study Date:
(please enclose previous test results)

_____

Location: _____
☐ Diabetes
☐ Seizures/Epilepsy
☐ Morbid Obesity
☐ Asthma
☐ Mood / Anxiety Disorder
☐ Chronic Pain
Other Conditions:

_____

_____

For Office Use:

REFERRAL REQUEST

☐ Urgent ☐ Routine ☐ Safety Critical Occupation
☐ CONSULTATION *(REQUIRED if patient has had a previous study/diagnosis)*
☐ SLEEP STUDY AND CONSULTATION
☐ DIAGNOSTIC SLEEP STUDY ONLY *(no previous testing)*

PATIENT INFORMATION

Name _____
OHIP _____ Version Code _____
Height _____ Weight _____
Date of Birth _____ Sex (at birth) _____
Home Phone _____ Cell Phone _____
Home Address _____
City _____ Postal Code _____
Email _____

REFERRING PRACTITIONER

Name _____
Billing # _____
Address _____
City _____ Postal Code _____
Phone _____ Fax _____
Practice Model so you will not be negated:
☐ FHT ☐ FHO ☐ FHG ☐ FHN ☐ FFS ☐ HSO
FAMILY PHYSICIAN (if different)
Name _____ Fax _____

CURRENT MEDICATIONS WITH DOSES OR LIST ATTACHED

SPECIAL ACCOMMODATIONS

☐ Language
☐ Ambulation
☐ Care Assistance (Caregiver/ Parent)

Referring Practitioner Signature: _____ Date: _____