MedSleep

☐ Brampton Sleep Clinic	Fax: 905-456-8768
☐ Etobicoke - Queensway Sleep Clinic	Fax: 416-622-7831
☐ MedSleep Corktown	Fax: 416-703-0507
☐ MedSleep Milton	Fax: 905-203-2882
☐ Mississauga - Tri-Hospital Sleep Laboratory	Fax: 905-566-0440
☐ Niagara Snoring and Sleep Center	Fax: 1-888-905-6992
☐ Toronto Sleep Institute-Bayview	Fax: 416-488-3998
☐ Toronto Sleep Institute-Thornhill	Fax: 905-709-9764

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: _____