



- MedSleep Campbell River
- Nanaimo Sleep Clinic
- MedSleep Langford
- MedSleep Saanich
- MedSleep Coquitlam
- Kootenay Sleep Center (Cranbrook)
- Castlegar Sleep Center
- MedSleep Penticton
- Williams Lake Sleep Center
- MedSleep Prince George
- Dawson Creek Sleep Center
- Northern BC Sleep Center (Terrace)

- Fax: 1-844-652-7386
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- Fax: 778-517-5722
- Fax: 778-460-0036
- Fax: 1-844-652-7386
- Fax: 778-412-9323
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- Fax: 250-784-0268
- Fax: 250-638-1068

REASON FOR REFFERAL

- Snoring/Sleep Apnea
- 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
(please enclose previous test results)

Currently Adherent to therapy?
 Yes No

- Diabetes
- Seizures/Epilepsy
- Morbid Obesity
- Asthma
- Mood / Anxiety Disorder
- Chronic Pain

Other Conditions:

REFERRAL REQUEST

- Urgent Routine Safety Critical Occupation
- CONSULTATION AND SLEEP STUDY *(as appropriate)*
- HOME SLEEP APNEA TESTING
(MUST include BC Ministry of Health Form A: Requisition for Home Sleep Apnea Test (HSAT))

PATIENT INFORMATION

Name: _____
 PHN: _____ Date of Birth: _____
 Sex (at birth): _____ Gender: M F Other
 Home Phone: _____ Cell Phone: _____
 Home Address: _____
 City: _____ Postal Code: _____
 Email: _____
 Height: _____ Weight: _____

REFERRING PRACTITIONER

Name _____
 Billing # _____
 Address _____
 City _____ Postal Code _____
 Phone _____ Fax _____
 FAMILY PHYSICIAN (if different)
 Name _____ Fax _____

CURRENT MEDICATIONS WITH DOSES OR LIST ATTACHED

SPECIAL ACCOMMODATIONS

- Language
- Ambulation
- Care Assistance
(Caregiver/Parent)
- Other: _____

Physician Signature: _____

Date: _____