



- Brampton Sleep Clinic \_\_\_\_\_ Fax: 905-456-8768
- Etobicoke - Queensway Sleep Clinic \_\_\_\_\_ Fax: 416-622-7831
- MedSleep Corktown \_\_\_\_\_ Fax: 416-703-0507
- MedSleep Downsview \_\_\_\_\_ Fax: 416-635-0300
- 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: \_\_\_\_\_