

## SLEEP DISORDER REFERRAL FORM

PLEASE FAX THIS FORM TO: 416-622-7831

### PERSONAL INFORMATION

Name \_\_\_\_\_  
OHIP Number \_\_\_\_\_  
Birth Date \_\_\_\_\_ Age \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Gender:  M  F  
Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Email \_\_\_\_\_

### REFERRING PHYSICIAN

Physician \_\_\_\_\_  
Billing # \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_

Phone \_\_\_\_\_  
Fax \_\_\_\_\_  
Email \_\_\_\_\_

### REFERRAL FOR

SLEEP STUDY ONLY (Please complete sections 1–5 below) OR  CONSULTATION AND SLEEP STUDY, IF INDICATED (Please complete sections 1–3 below)

• Has the referred patient had a previous sleep study?  Yes  No

• If yes, please provide the date of the last sleep study: \_\_\_\_\_ Location: \_\_\_\_\_

### HISTORY AND PHYSICAL INFORMATION

#### 1 HISTORY OF SLEEP PROBLEM

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Snoring                      | <input type="checkbox"/> Insomnia                        | <input type="checkbox"/> Shift Work              |
| <input type="checkbox"/> Witnessed Apneas             | <input type="checkbox"/> Frequent Awakenings             | <input type="checkbox"/> Cataplexy               |
| <input type="checkbox"/> Excessive Daytime Sleepiness | <input type="checkbox"/> Restless Legs Syndrome          | <input type="checkbox"/> Sleepwalking/Nightmares |
| <input type="checkbox"/> Nocturia                     | <input type="checkbox"/> Periodic Limb Movement Disorder | <input type="checkbox"/> Other _____             |

#### 2 MEDICAL CONDITIONS

- |                                   |  |                                      |                                       |  |   |                                       |
|-----------------------------------|--|--------------------------------------|---------------------------------------|--|---|---------------------------------------|
| <input type="checkbox"/> MI/CAD   | <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> GERD        | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Mood Disorder | <input type="checkbox"/> Anxiety Disorder   | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke            | <input type="checkbox"/> Asthma/COPD | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> CHF           | <input type="checkbox"/> Cardiac Arrhythmia |                                       |

#### 3 MEDICATIONS

#### 4 RELEVANT FAMILY / SOCIAL / PERSONAL HISTORY (if request for sleep study only)

#### 5 PHYSICAL EXAM – POSITIVE FINDINGS (if request for sleep study only)

#### 6 SPECIAL NEEDS (i.e., assistance moving, difficulty communicating)

Physician's signature: \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE CHECK IF YOU WOULD LIKE US TO SEND YOU MORE REFERRAL FORMS.

FOR CLINIC USE ONLY: DATE: \_\_\_\_\_ STAT / ROUTINE PSG / P / R / NR / PED / OTHER: \_\_\_\_\_