

SLEEP DISORDER REFERRAL FORM PLEASE FAX THIS FORM TO: 613-257-0021**PERSONAL INFORMATION**

Name _____ Home Phone _____ Work Phone _____
OHIP # _____ VC _____ Street Address _____
Birth Date _____ Age _____ City _____ Postal Code _____
Height _____ Weight _____ Gender: M F Email _____

REFERRING PRACTITIONER

Physician/NP _____ Phone _____
Billing # _____ Fax _____
Street Address _____ Email _____
City _____ Postal Code _____

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

ELECTIVE **URGENT** If urgent, please explain: _____

① HISTORY OF SLEEP PROBLEM

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Nocturia | <input type="checkbox"/> Restless Legs Syndrome | <input type="checkbox"/> Cataplexy |
| <input type="checkbox"/> Witnessed Apneas | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Periodic Limb Movement Disorder | <input type="checkbox"/> Sleepwalking/Nightmares |
| <input type="checkbox"/> Excessive Daytime Sleepiness | <input type="checkbox"/> Frequent Awakenings | <input type="checkbox"/> Shift Work | <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 DOES THE PATIENT HAVE A SAFETY CRITICAL OCCUPATION?**

Yes No

⑤ SPECIAL NEEDS (i.e., assistance moving, difficulty communicating)

Physician/NP signature: _____ Date: _____

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