Good Sleep Health - Victoria

Thesleepclinics.ca

Patient Referral Requisition

Patient Name: _____ **Home Phone:** _____

Address: _____ **Work Phone:** _____

_____ **Email:** _____

DOB: d/m/yr _____ **PHN#:** _____

Referring Physician: _____ **Phone:** _____

Address: _____

_____ **Billing #:** _____

Type of referral:

☐ Sleep Disorders Consultation with Polysomnogram or Home Sleep Apnea Test (HSAT) as indicated

☐ Home Sleep Apnea Test (HSAT) – **PLEASE USE FORM A**

Reason for referral:

☐ Sleep Apnea	☐ Restless Legs Syndrome	☐ Chronic Fatigue/Fibromyalgia
☐ Excessive Daytime Sleepiness	☐ Periodic Limb Movements	☐ Oral Appliance Titration (Matrx study)
☐ Narcolepsy	☐ Parasomnia (eg: sleepwalking)	☐ Other (please specify)
☐ Chronic Insomnia	☐ Shift-work related problem	_____

Relevant History: _____

_____

_____

_____

Is this referral for disability or medico-legal purposes? ☐ Yes ☐ No

If this referral is URGENT, please explain: _____

Additional Comments or concerns: _____

PLEASE ENCLOSE copy of CBC, TSH, Oximetry or Sleep Study reports if available to prevent duplication.

We will contact the patient directly to book the appointment. Thank you for your referral.

FAX to: (604) 900-8251

Physician Signature:_____ **Date:** _____

#215 – 3561 Blanshard St. Building B, Victoria, BC V8Z 0B9 Phone: (778) 817-1696, Fax: (604) 900-8251