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) – **sleep apnea screening only**

Reason for referral:

Sleep Apnea

Excessive Daytime Sleepiness

Narcolepsy

Chronic Insomnia

Restless Legs Syndrome

Periodic Limb Movements

Parasomnia (eg: sleepwalking)

Shift-work related problem

Chronic Fatigue/Fibromyalgia

Oral Appliance Titration (Matrx study)

Other (please specify) ___________________________

Relevant History: ____

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

If this referral is URGENT, please explain: ____

Additional Comments or concerns: ____

<u>PLEASE ENCLOSE</u> 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: 250-862-3052

Physician Signature: _______________________________________ **Date:** ___________________________