



REFERRAL FORM

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(*Referrals are to be faxed to the above number and patients will be contacted directly for appointments.)

| PATIENT INFORMATION | | |
|--|---|---|
| SURNAME: _____ GIVEN NAME(S): _____ SEX: <input type="checkbox"/> M <input type="checkbox"/> F | | |
| ADDRESS: _____ CITY: _____ PROVINCE: _____ POSTAL CODE: _____ | | |
| DATE OF BIRTH: (M/D/Y) _____ AHC #: _____ | | |
| HOME PHONE: _____ WORK PHONE: _____ OCCUPATION: _____ | | |
| REFERRED BY: _____ PRACID : _____ | | |
| ADDRESS: _____ CITY: _____ PROV: _____ POSTAL CODE: _____ | | |
| PHONE: _____ FAX: _____ FAMILY PHYSICIAN: _____ | | |
| <input type="checkbox"/> OBSTRUCTIVE SLEEP APNEA (SNORING) | <input type="checkbox"/> OBESITY (WEIGHT MANAGEMENT) | <input type="checkbox"/> MOOD DISORDER (SEASONAL AFFECTIVE DISORDER, DEPRESSION, ANXIETY) |
| <input type="checkbox"/> INSOMNIA (NON-RESTORATIVE SLEEP) | <input type="checkbox"/> MOVEMENT DISORDERS (RESTLESS LEG SYNDROME) | <input type="checkbox"/> SAFETY SENSITIVE OCCUPATION SPECIFY: _____ |
| <input type="checkbox"/> EDS (EXCESSIVE DAYTIME SLEEPINESS) | <input type="checkbox"/> PARASOMNIA SPECIFY: _____ | <input type="checkbox"/> SHIFTWORKER |
| CURRENT MEDICATIONS/ ADDITIONAL MEDICAL INFO: | | LABORATORY RESULTS: |
| | | TSH _____ PFT _____ |
| | | HBG _____ FERRITIN _____ |
| | | EKG _____ |
| | | OTHER: _____ |

| FOR OFFICE USE ONLY | | |
|---|---|--|
| <input type="checkbox"/> URGENT | <input type="checkbox"/> NON-URGENT | APPT DATE: _____ |
| <input type="checkbox"/> PREVIOUS LEVEL I SLEEP STUDY | <input type="checkbox"/> PREVIOUS LEVEL III SLEEP STUDY | <input type="checkbox"/> CURRENTLY ON CPAP |
| COMMENT: _____ INITIAL : _____ DATE: _____ | | |