SLEEP STUDY REFERRAL FORM

Fax this form to: 905.554.5505 **For More Info. Call : 905.554.5503**

SLEEP DISORDER REFERRAL FORM

Patient Information:

Patient Name: Last ____________________ First ____________________ Gender: ☐ Male ☐ Female

OHIP: ________________________ | version code DOB: DD | MM | YYYY Height: ______ (cm/ft) Weight: ______ (kg/lbs)

Address: ____ Postal Code: ____________________

Home Phone: ____________________ Cell Phone: ____________________ Work Phone: ____________________

Email Address: ____ Preferred Language: ____________________

Emergency Contact: ____ Contact Number: ____________________

Referral Requested:

☐ Sleep Study Only (if no prior sleep study done) ☐ Consult & Sleep Study if Indicated ☐ Consult Only (if prior sleep study done)

Has the patient had a previous sleep study? No ☐ Yes ☐ Date: ____________________

Referring Physician:

Name: ____ (please print) OHIP Billing Number: ____________________

Mailing Address: ____ Postal Code: ____________________

Phone Number: ____________________ Fax Number: ____________________ Email: ____________________

Reason for Referral: ____ ☐ CPAP Follow Up

☐ Snoring	☐ Nocturia	☐ Cardiovascular Risk Factors/CHF
☐ Excessive Daytime Sleepiness	☐ Insomnia	☐ Abnormal Behaviour During Sleep
☐ Restless Legs	☐ Fibromyalgia	☐ Witness Apneas/Frequent Awakenings
☐ Headaches	☐ Obesity	☐ Other: ____________________

Past Medical History: ____

Medications: ____ Allergies: ____________________

On Oxygen: ☐ No ☐ Yes ________ LPM On CPAP: ☐ No ☐ Yes: ________ cmH_2O

Physician Signature: ____ Date: ____________________

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

Office Use Only: Appointment Date: ____________________ Time: ____________________