



REFERRAL

Date (YYYY/MM/DD): _____

Telephone 519-667-6855 / Fax 519-667-6715

Please note that patients may be scheduled directly into the sleep laboratory at the discretion of the laboratory physician depending upon clinical circumstances. The clinical information is mandatory. If the referral is not fully completed, it will be returned to you without an appointment and this patient will need to be re-referred.

Patient Information (All fields required)

PIN: _____
 Name _____
 DOB (YYYY/MM/DD) _____
 Current Address _____
 City _____ Postal Code _____
 Home () _____ Work () _____
 Health Card _____ Version Code _____
 Email _____

Referring Physician Information (All fields required)

Name _____
 Current Address _____
 City _____ Postal Code _____
 Phone () _____ Fax () _____
 OHIP REFERRAL # _____
Physician's Signature:
 Family Physician _____

Prior sleep study done? Yes No If Yes, where was it done? LHSC Other (Please provide copy)

Reason For Referral:

Snoring Sleep Apnea Narcolepsy Insomnia Excessive Daytime Sleepiness
 Re-assessment Other _____

Please check (✓):

Professional driver Currently using CPAP/BiPAP PaCO₂ ≥ 45
 Prefers day sleep study (night shift worker) (attach supporting information)

Allergies (drug, food, environmental, latex, etc.):

Contact Precautions:

MRSA C. Difficile (Active)

Relevant Medical History:

MUST Complete

Medications: Please attach list

Height: _____ cm **Weight:** _____ kg

STOP-Bang score: _____ Epworth Sleepiness score: _____

Sleep Physician Requested:

M. Sen J. Barr A. Kashgari H. Racz W. Reisman No Preference

OFFICE USE ONLY

Previous Lab: _____ **Previous Clinic:** _____

AHI: _____

R/O OSA Split Night ASV Video Record
 May Split BiPAP _____ Repeat Sleep Logs TcCO₂
 CPAP _____ Post-op _____ Clinic New/Fup _____ Other: _____

Appointment Date:

Lab: _____ Clinic: _____

Mail _____ Fax _____ Email _____

E S