NORTH TORONTO SLEEP CENTRE

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Sleep Disorders Referral Form

SERVICES REQUESTED

❑ **Sleep Study, followed by consultation**
❑ **Sleep Study only**
❑ **Consultation, followed by sleep studies**
❑ **Consult only**

Has the patient had a previous sleep study? ❑ No ❑ Yes Date: _____ **Urgent?** ❑ No ❑ Yes

Patient Name _____ Sex ❑ M ❑ F
(PLEASE PRINT) (LAST) (FIRST)

OHIP # _____ | | | ❑ Non-OHIP. DOB (D/M/Y)____/____/_____
VERSION CODE

Address _____

Cell Number ( )_____ **Home Number** ( )_____ **Bus. Number** ( )_____

Email _____

Emergency Contact:_____ **Tel. Number** ( )_____

Available on Short Notice? ❑ Yes ❑ No

Requesting Physician _____ Billing Number _____

Mailing Address _____

Tel. Number ( ) _____ Fax Number ( )_____

Family Physician _____ Fax Number ( )_____

Patient Complaint/Inquiry

❑ Snoring
❑ Excessive Daytime Sleepiness (EDS)
❑ Insomnia
❑ Witnessed Apneas
❑ R/O Sleep Apnea
❑ Morning Headaches
❑ Restless Legs/Leg Cramps
❑ Fibromyalgia/Chronic Fatigue
❑ Obesity
❑ Other: _____

Special Instructions: _____

Medications/Allergies: _____

Physician Signature: _____ Date: _____

LAB USE ONLY

Procedure

❑ Initial Diagnostic Sleep Study (PSG)
❑ Repeat PSG*
❑ PSG followed by MSLT* ❑ MWT*
❑ Seizure Montage*
❑ Parasomnia Montage*
❑ CPAP ❑ CPAP F/U
❑ BPAP: Starting Pressure_____ ❑S ❑S/T
❑ CO_2 Monitoring
❑ Oral Appliance Titration
❑ Positional Therapy

***Consultation Required**

Appointment Data & Time: _____

Referring Physician: _____ **Interpreting Physician:** _____