THE CENTRE FOR SLEEP AND CHRONOBIOLOGY

SleepMed.ca

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Patient Referral Information

Patient's Name: _____ DOB (dd/mm/yyyy): _____

Address: _____

Telephone (Home): _____ Cell: _____

Health Card Number: _____ V/C: _____

Request for: ☐ Sleep Study & Consultation ☐ Sleep Study Only ☐ Consultation Only

Reason for Referral

☐ Sleep Apnea ☐ Insomnia ☐ Non-Restorative Sleep ☐ Sleepiness
☐ Sleep Schedule Disorder ☐ Restless legs ☐ Nocturnal Seizures ☐ Other
☐ Parasomnias/ Sleep Behavioral Disorders

Details, if "Other" _____

Current Medications: _____

Medical History: _____

Previous Sleep Studies? ☐ Yes (Provide reports) ☐ No Date of Previous Sleep Study: _____

Referring Physician's Information

Physician's Name: _____ Physician's Billing No: _____

Physician's Address: _____

Physician's Telephone: _____ Physician's Fax: _____

Date (dd/mm/yyyy): _____ Physician's Signature: _____