



THE CENTRE FOR SLEEP AND CHRONOBIOLOGY

SleepMed.ca

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College Site

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Wilson Site

1054 Wilson Ave, North York, ON M3K 1G6
Tel. (416) 746-3012; Fax (416) 746-7016

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: _____