YRSDC
YORK REGION SLEEP DISORDERS CENTRE

# SLEEP DISORDER REFERRAL FORM

## PERSONAL INFORMATION:

Please fax this form to **905 773-9614**

PLACE PATIENT LABEL HERE

Last Name: _____ First Name _____

Address: _____

OHIP Number _____ Birth Date: _____
mm / dd / yy

Home Phone: _____ Work Phone: _____

Cell: _____

Age: _____ Height: _____

Weight: _____ Gender: M / F

REFERRING Dr. s STAMP HERE or if no stamp please supply information - *print clearly:*

Name _____

Full Address _____

Phone _____

Fax _____

Billing # _____

Dr. s Signature _____

Date _____

Referral for: ☐ **Diagnostic sleep study only** ☐ **Consultation and sleep study if indicated**
(Please complete sections 1 - 3)

☐ **Diagnostic sleep study with consultation if abnormal**
(Please complete sections 1 - 5)

## HISTORY AND PHYSICAL INFORMATION

_____

_____

_____

**1) History of Sleep Problem**

____ Excessive Daytime Sleepiness (Consultation is recommended)
_____ Shift Work
_____ Claustrophobia
_____ Witnessed Apneas

____ Morning Headaches
_____ Cataplexy
_____ Insomnia (Treatment Resistant)
_____ Sleep Paralysis

____ Snoring
_____ Nocturia
_____ Frequent Awakenings
_____Sleepwalking

**2) Medical Conditions**

____ MI/CAD
_____ Seizures/Epilepsy
_____ GERD
_____ Fibromyalgia
_____ ALS

____ Diabetes
_____ Stroke
_____ Asthma/COPD
_____ Chronic Pain
_____ CHF

**3) Medications**

_____

_____

**4) Relevant Family/Social/Personal History (if request for sleep study only)**

_____

_____

_____

**5) Physical Exam - positive findings (if request for sleep study only)**

_____

_____

**6) Special Needs (i.e. assistance moving, difficulty communicating)**

_____

_____

**Physician Signature:** _____ **Date:** _____

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