VAUGHAN SLEEP CLINIC

SLEEP DISORDER REFERRAL FORM

Please fax this form to **905-856-0900**

PERSONAL INFORMATION

PLACE PATIENT LABEL HERE

Last Name: _____ First Name: _____

Address: _____

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

Phone (H): _____ Phone (W): _____

Cell: _____

Age: _____ Height: _____

Weight: _____ Gender: ❒ M ❒ F

REFERRING Dr. 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

❒ Diagnostic sleep study with consultation if abnormal
(please complete sections 1-5)

❒ Consultation and sleep study if indicated
(please complete sections 1-3)

HISTORY & PHYSICAL INFORMATION

_____

_____

_____

1) History of Sleep Problems

❒ 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:** _____