MDAC | Medical Diagnostics & Consulting

1-820 Red River Road Thunder Bay, ON P7B 1K2
P 807-683-4415 F 807-683-4420 **www.mdac-ca.com**
M. J. Mosley Respiratory Therapy Professional Corporation

SLEEP DISORDERS REFERRAL FORM

Please complete and fax to (807) 683-4420 Urgent Requests Require a Physician to Physician Phone Call

SERVICES REQUESTED - PLEASE SELECT **ONE**

○ Sleep Study, followed by consultation (for treatment interventions, if indicated) ○ Sleep Study Only ○ Sleep Consult Only

Insomnia alone is not an indication for sleep studies and requires consultation first. Consultations/clinical follow up may be provided via Telemedicine.

PATIENT INFO Name, DOB, Gender, HNON, Address, Phone (home/work/cell)

PRIOR SLEEP STUDY HISTORY

Date:

Results attached **Y** **N**

On Treatment **Y** **N**

Type & Rx CPAP _____ cmH20
BiPAP _____ cmH20
ASV _____ cmH20

Oxygen **Y** **N** _____ Lpm

CLINICAL INFO RELEVANT TO THE TEST

- ○ Witnessed or suspected apnea
- ○ Drowsiness
- ○ Obesity
- ○ Morning Headache or sore throat
- ○ Family History of Sleep Apnea
- ○ Snoring
- ○ Insomnia
- ○ Frequent Awakenings
- ○ Nightmares
- ○ Abnormal Sleep Behaviours (ie. waking, terrors, violence)
- ○ Restless legs / leg cramps
- ○ Other _____

WHAT QUESTIONS DO YOU WANT ANSWERED?

MEDICAL HISTORY

○ Diabetes	○ CHF	○ Fibromyalgia	○ Cardiac Arrhythmia
○ Hypertension	○ Angina	○ Anxiety/Depression	○ Chronic Pain
○ Stroke	○ GERD	○ Diabetes	○ Asthma/COPD

○ Current Meds _____

LIST ANY ISSUES AFFECTING PRIORITY/ BOOKING, or MAJOR COMORBIDITIES:

Major Accessibility Issues _____ Hearing _____ Language Barrier _____ Cognitive Impairment _____ Mobility/Transfers _____

REFERRING PHYSICIAN (All requests must be made by a member of the CPSO)

Name: _____ Billing Number: _____ Date: _____

Address/Phone/Fax: _____

CC: _____ MD Signature:

Append cumulative summary/problem list, relevant consults and any prior sleep studies