MDaC | Sleep Inc.

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SLEEP DISORDERS REFERRAL FORM

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

This requisition form can be taken to any licensed facility providing healthcare services including hospitals and IHFs, such as those listed on the IHF Program website: http://www.health.gov.on.ca/en/public/programs/ihf/facilities.aspx

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))

Previous in-lab sleep study? Y ○ N ○ (If yes, please attach results)
On CPAP/BiPAP therapy? Y ○ N ○ ________cm H20
On oxygen therapy? 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
- ○ Hypertension
- ○ Stroke
- ○ CHF
- ○ Angina
- ○ GERD
- ○ Fibromyalgia
- ○ Anxiety/Depression
- ○ Diabetes
- ○ Cardiac Arrhythmia
- ○ Chronic Pain
- ○ 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/NP (All requests for sleep studies must be made by a member of the CPSO/CNO)

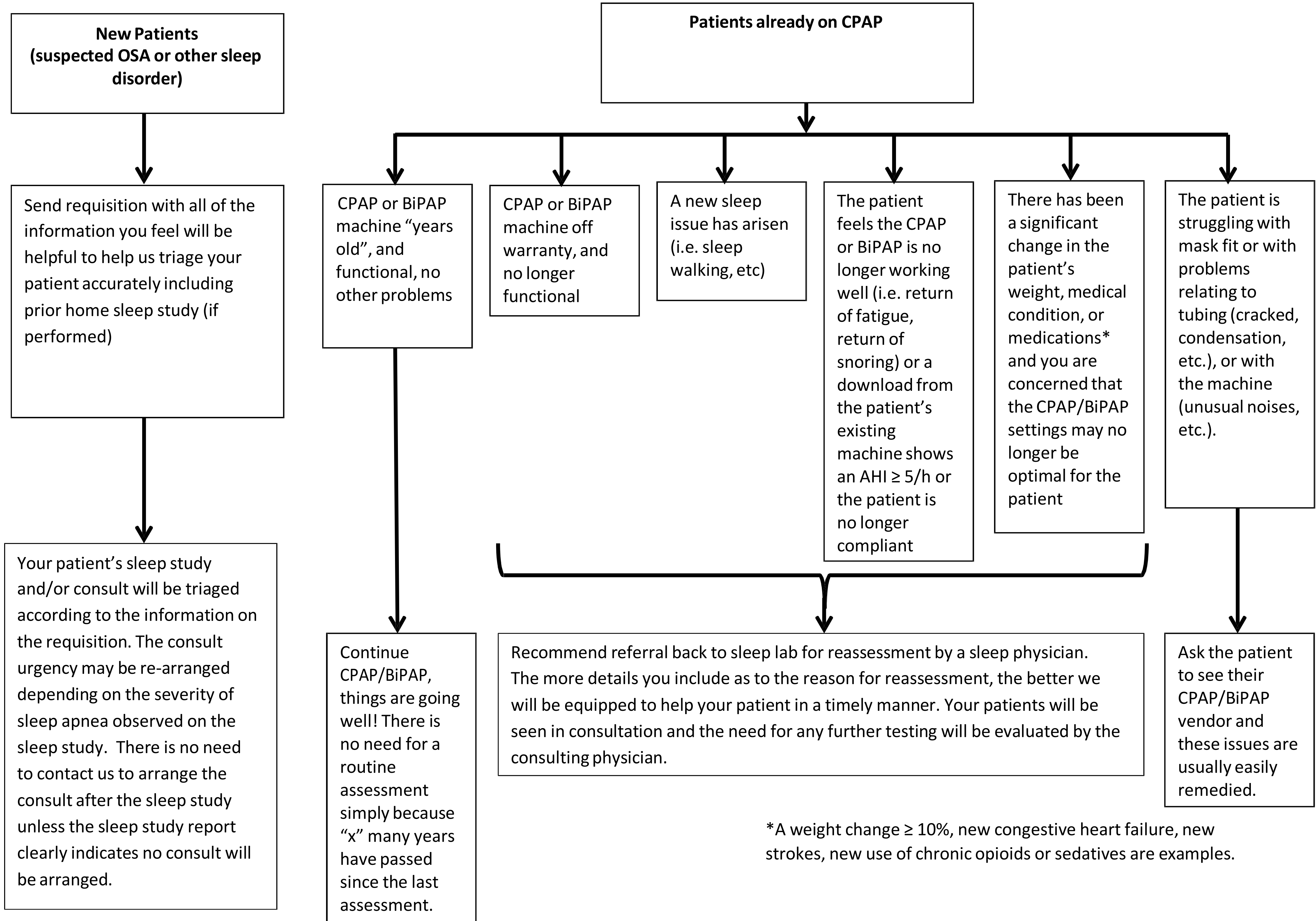
Name:________________________________Billing Number:____________________Date: ________________

Address/Phone/Fax: ________________________________

CC:________________________________MD/NP Signature:

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

Referral Algorithm for Sleep Patients in Thunder Bay



*A weight change ≥ 10%, new congestive heart failure, new strokes, new use of chronic opioids or sedatives are examples.