Carling Respiratory Services

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Sleep Medicine Referral

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REFERRING PHYSICIAN INFORMATION

Billing # ______ Physician Name ______

Phone # ______ Fax # ______

PATIENT INFORMATION/STICKER

Patient Name ______

OHIP # ______ VC ______

Address ______

DOB (DD-MM-YY) ______ Home/Cell Phone # ______

CONSULT DETAILS

- Consultation includes polysomnogram if indicated.
  Please indicate urgency below:
  ☐ Routine ☐ Urgent
- Previous Polysomnogram:
  ☐ No ☐ Yes, specify when & where:
  ______
- Reason(s) for Referral:
  ☐ R/O Sleep Apnea
  ☐ Replacing Existing Positive Pressure Device
  ☐ Excessive Daytime Sleepiness
  ☐ Insomnia
  ☐ Limb Movements (PLMS/RLS)
  ☐ Parasomnias (Sleep Walking etc.)
  ☐ Other: ______
- Patient Occupation: ______

REASON FOR REFERRAL

In order to ensure timely triage of this patient, please attach patient profile including updated medication list & all relevant notes/test results.