Carling Respiratory Services

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Rapid Access OSA Clinic

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REFERRING PHYSICIAN INFORMATION

Billing # Physician Name

Phone # Fax #

Address

PATIENT INFORMATION/STICKER

Patient Name

Email: _____

OHIP # VC

Address

H#:

M#:

DOB (DD-MM-YY) Phone #

CONSULT DETAILS

- Consultation +/- PSG 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
  ☐ Portable PSG
  ☐ Other: _____
- Patient Occupation: _____

REASON FOR REFERRAL (Required)

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