BRITISH COLUMBIA | Ministry of Health

Surrey Sleep Clinic
Fax: 604-372-0134

FORM B: REFERRAL REQUEST – SLEEP DISORDER CONSULTATION

PATIENT INFORMATION (*denotes required field)

Last Name*	First Name*	PHN*

Date of Birth* (YYYY / MM / DD)	Gender	Preferred Language

Primary Contact Number*	Secondary Contact Number	Email

Address

Safety Critical Occupation* – *if Yes, provide detail in Patient History*

◯ Yes ◯ No (e.g. truck, taxi, bus drivers; airline/marine pilots; emergency personel; constructution workers; etc.)

Patient History and Comorbid Conditions

Allergies and Medications

REFERRING PRACTITIONER

Name*

MSP Number*

Clinic Name

Street Address STAMP

Phone Fax

Primary Care Provider*

◯ Same as Referring Practioner ◯ None

Copy to (full name and Speciality or MSP Number)

REASON FOR REFERRAL

Reason for Referral

This is an urgent referral ◯ Yes ◯ No (If Yes, provide detail:)

The following patient information is included in this referral:

- ☐ Pertinent patient history/medical notes (including relevant reports from sleep disorder physicians or other practitioners)
- ☐ Recent blood work and lab reports
- ☐ Relevant radiology reports
- ☐ All available sleep studies (HSAT or polysomnogram) and PAP therapy results
- ☐ Other: _____

SIGNATURE

Thank you for seeing this patient in consultation.

Please contact patient directly with appointment information and let our office know the approximate wait time.

Should you have any issue communicating with this patient, please let us know.

☐ ☐

Referring Practitioner Signature

Date Signed (YYYY / MM / DD)

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HLTH 1945 2021/05/26

Online 2022

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