SLEEP DISORDERS REFERRAL FORM

Surey Sleep Clinic & Laboratory

(PLEASE FAX FORM TO 604-372-0134)

City Centre 2
Suite 306, 9639 137A Street
Surrey, BC, Canada V3T 0M1
Tel: 604-372-0133 Fax: 604-372-0134
www.surreysleepclinic.com

New address effective August 2019

☐ **Urgent** ☐ **Non-Urgent** ☐ **Safety critical job** ☐ **Work Safe** ☐ **Pediatric (Age > 8)**

Date:

Patient:

Name ______________________________ PHN ________________________________
Phone _____________________________ Mobile ______________________________
Address ____
DOB (M/D/Y) _______________________ Gender ______________________________

Referring Physician:

Name ______________________________ MSP # ______________________________
Phone _____________________________ Fax ________________________________
Clinic Address ____

Please Choose:

☐ **Sleep Medicine Consultation with Dr. A. S. Minhas or Delegate**

☐ **Overnight Polysomnography** – (Level 1)

(Sleep Medicine consult is required for Level 1 Polysomnography, CPAP or Dental titration, MWT, MSLT & other in-lab tests)

☐ **Level 3 Home Sleep Apnea Study and CPAP Initiation** *(Rapid access, no sleep medicine consultation required)*

☐ **Level 3 Home Sleep Apnea Study** *(Rapid access, no sleep medicine consultation required)*

Reason for Referral:

☐ Obstructive Sleep Apnea (OSA) ☐ Sleepy while driving ☐ Excessive sleepiness/fatigue
☐ Central Sleep Apnea ☐ Insomnia ☐ REM behaviour disorder
☐ Narcolepsy ☐ Restless Leg Syndrome ☐ Parasomnia/Somnambulism
☐ **Other**

Medical History:

☐ Hypertension ☐ Heart Failure ☐ CAD/MI ☐ A. Fib ☐ CVA/TIA
☐ Obesity ☐ Hypothyroid ☐ Diabetes ☐ COPD
☐ Migraine ☐ Chronic Pain ☐ Opioid Rx ☐ Restrictive lung disease
☐ Depression ☐ Bruxism ☐ ED/Testosterone Rx ☐ Neuromuscular disease

Other Medical History:

Medications:

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Physician Signature

Online_2021