SLEEP DISORDERS REFERRAL FORM

(PLEASE FAX FORM TO 604-372-0134)

Surrey Sleep Clinic & Laboratory

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** ☐ **Pediatric (Age > 8)**

Date: _____

Patient Name: _____

PHN _____ DOB _____ Gender _____
Phone _____ Mobile _____
Address _____ City_____ Postal Code _____

Referring Physician Name: _____ MSP # _____

Phone _____ Fax _____
Clinic Address _____ City _____

Please Choose:

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

☐ **Overnight Polysomnography** *(Level 1) – Please provide HSAT report, if available*

(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** *(Rapid access, no sleep medicine consultation required)*

☐ **CPAP Initiation** *(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 ☐ COPD ☐ Restrictive lung disease
☐ Obesity ☐ Hypothyroid ☐ Diabetes ☐ CVA/TIA ☐ Neuro-muscular disease
☐ Migraine ☐ Chronic Pain ☐ Opioid Rx ☐ Depression
☐ Other _____

Medications:

_____

Physician Signature