The Sleep Institute

The Sleep Institute
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PATIENT REFERRAL FORM

Once the referral form is submitted, patients will be contacted directly for appointments.

Surname: _____ Given Name(s): _____ Sex: ☐ M ☐ F

Address: _____
City *Province* *Postal Code*

Date of Birth: ☐☐ / ☐☐ / ☐☐ Personal Health Care #: _____
Month *Day* *Year*

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Occupation: _____

Referred By: _____ MD Pracid: _____

Address: _____
City *Province* *Postal Code*

Phone: _____ Fax: _____ Family Physician: _____
(if different from Referring Physician)

Mandatory - Check all that apply:

Primary Sleep Concerns:
- ☐ Obstructive Sleep Apnea (Snoring)
- ☐ Insomnia (Non-Restorative Sleep)
- ☐ Excessive Daytime Sleepiness (includes Narcolepsy)
- ☐ Shift Work/Jet Lag/Delayed Sleep Phase
- ☐ Athlete

Movement Disorders:
- ☐ Restless Legs Syndrome
- ☐ Periodic Limb Movement Disorder
- ☐ Sleep Bruxism
- ☐ Other, please specify:

Parasomnia:
- ☐ Sleepwalking/Night Terrors
- ☐ Violent behavior in sleep
- ☐ Nightmares
- ☐ Other, please specify:

Safety Sensitive Occupation:
- ☐ Professional Driver
- ☐ Airline Pilot/Flight Staff
- ☐ Doctor / Nurse
- ☐ Oilfield Worker
- ☐ Railroad Engineer/Conductor
- ☐ Emergency First Responder (EMS/Police/Fire)
- ☐ Other, please specify:

Current Medications / Additional Medical Information:

For Office Use Only

Copies of these referral forms can also be downloaded from our website at www.thesleepinstitute.ca (under "Referrals") and returned by fax or email.