



Centre for Sleep and Chronobiology Sleep Disorders Clinics

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www.sleepmed.to

PATIENT REFERRAL INFORMATION:

Name: _____ D.O.B.: _____
(dd/mm/yy)

Address: _____

(postal code)

Telephone: H) () _____ B) () _____

Health Card Number: _____ Version Code: _____

REQUEST FOR: (PLEASE CHECK)

Sleep Study and Consultation Sleep Study Consultation

REASON FOR REFERRAL: (PLEASE CHECK)

Sleep Apnea Insomnia Nonrestorative sleep Sleep Schedule Disorder
 Restless legs Sleepiness Nocturnal Seizures Parasomnias (sleep terrors, sleep walking)

CURRENT MEDICATIONS:

RELEVANT MEDICAL HISTORY (please attach pertinent documentation):

SLEEP STUDIES IN PAST 12 MONTHS? NO YES (If yes, please provide reports)

Physician's Name (Please print): _____

Physician's Address: _____

Physician's Tel. No.: () _____ Fax No.: () _____

Physician's Billing No.: _____

Physician's Signature: _____ Date: _____

Check here if you require more referral forms.