SleepCareHub

Fax: 905-886-9618
www.sleepcarehub.com

SLEEP DISORDER REFERRAL FORM

Please complete the form and fax to 905-886-9618

PATIENT INFORMATION

Name:			
DOB (DD/MM/YY): / /			
Health Card:			Version Code:
Email:			
Telephone - Primary:			Secondary:
Address:			
☐ M ☐ F	Age:		Occupation:

REASON FOR REFERRAL AND SLEEP ISSUES

☐ Snoring	☐ Daytime Sleepiness
☐ Witness Breathing Pauses	☐ Difficulty Falling Asleep
☐ Nocturia	☐ Difficulty Staying Asleep
☐ Morning Headaches	☐ Daytime Fatigues

Others:

MEDICAL HISTORY:

- ○ Hypertension
- ○ Diabetes
- ○ Heart disease
- ○ Stroke
- ○ Chronic Pain
- ○ Fibromyalgia

Other Medical Conditions:

Current Medications:

Has your patient had a previous sleep study? Y ☐ N ☐ If Yes, was it within last 2 years? Y ☐ N ☐

Physical Exam - Positive Findings

Special Needs (i.e. assistance moving, difficulty communicating)

REFERRING PHYSICIAN

Name:	
Phone/Fax:	OHIP Billing Number:
Address:	
Signature:	Date: