



atlanticsleepinstitute

TEST REQUESTED

- In-Clinic Full Polysomnographic Sleep Study (Level 1 Test)
- In-Home Sleep Apnea Screening Study (Level 3 Test) followed by consultation
- Sleep Medicine Consultation Only
- In-Home Sleep Apnea Screening Study Only

PATIENT INFO

Name _____ City/Town _____

Daytime Phone _____ Evening Phone _____

Age _____

SYMPTOMS:

- Snoring
- Insomnia
- Witnessed Apneas
- Excessive Daytime Fatigue
- Excessive Daytime Sleepiness
- Restless Legs Syndrome
- Other _____

MEDICAL CONDITIONS:

- MI/CAD
- Seizures/Epilepsy
- GERD
- Fibromyalgia
- Mood Disorder
- Anxiety Disorder
- Hypertension
- Diabetes
- Stroke
- Asthma/COPD
- Chronic Pain
- CHF
- Cardiac Arrhythmia
- Other _____

COMMENTS / MEDICATIONS:

PHYSICIAN INFO

Physician _____ Phone _____ Date _____

Signature _____ Fax results to _____

PLEASE FAX THIS FORM TO

Lower Sackville, NS 153 Sackville Drive, Lower Sackville, Nova Scotia B4C 2R3
Phone: 902-865-9698 • Fax: 902-865-9266

Dartmouth, NS 46 Portland Street, Suite 210, Dartmouth, Nova Scotia B2Y 1H2
Phone: 902-407-4647 • Fax: 902-407-4648 • Email: asidart@eastlink.ca

For further information on fees please contact us directly.

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