

SLEEP DISORDER REFERRAL • Lower Sackville / Dartmouth



atlanticsleepinstitute

TEST REQUESTED

- | | |
|---|--|
| <input type="checkbox"/> In-Clinic Full Polysomnographic Sleep Study (Level 1 Test) | <input type="checkbox"/> In-Home Sleep Apnea Screening Study (Level 3 Test) followed by consultation if abnormal results |
| <input type="checkbox"/> Sleep Medicine Consultation Only | <input type="checkbox"/> In-Home Sleep Apnea Screening Study Only |

PATIENT INFO

Name _____ City/Town _____

Daytime Phone _____ Evening Phone _____

Age _____

SYMPTOMS:

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

MEDICAL CONDITIONS:

- | | |
|--|---|
| <input type="checkbox"/> MI/CAD | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> GERD | <input type="checkbox"/> Asthma/COPD |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Chronic Pain |
| <input type="checkbox"/> Mood Disorder | <input type="checkbox"/> CHF |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Cardiac Arrhythmia |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Other _____ |

COMMENTS / MEDICATIONS:

PHYSICIAN INFO

Physician _____ Phone _____ Date _____

Signature _____ Fax results to _____

PLEASE FAX THIS FORM TO

Lower Sackville, N.S. Fax: (902) 865-9266 153 Sackville Drive – Phone: (902) 865-9698

Dartmouth, N.S. Fax: (902) 407-4648 46 Portland Street, #210 – Phone: (902) 407-4647

For further information on fees please contact us directly.

MedSleep

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