

SLEEP DISORDER REFERRAL • Truro / Bridgewater



atlanticsleepinstitute

TEST REQUESTED

- In-Clinic Full Polysomnographic Sleep Study (Level 1 Test)
- In-Home Sleep Apnea Screening Study Only
- Sleep Medicine Consultation 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:

- 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

Truro, N.S. Fax: (902) 843-3854 35 Commercial Street, #310 – Phone: (902) 843-3125
Bridgewater, N.S. Fax: (902) 530-3319 129 Aberdeen Road – Phone: (902) 530-3318

For further information on fees please contact us directly.

MedSleep

info@halifaxsleep.com www.halifaxsleep.com