

## SLEEP DISORDER REFERRAL FORM

### PLEASE FAX THIS FORM TO: 780-487-3045

#### PERSONAL INFORMATION

Name \_\_\_\_\_ Home Phone \_\_\_\_\_  
 AHCIP Number \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Street Address \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ Gender:  M  F City \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_  
 Email \_\_\_\_\_

#### REFERRING PHYSICIAN

Physician \_\_\_\_\_ Phone \_\_\_\_\_  
 PRACID # \_\_\_\_\_ Fax \_\_\_\_\_  
 Street Address \_\_\_\_\_ Email \_\_\_\_\_  
 City \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_

**REFERRAL FOR** (please check **one or more** boxes below)

In-Home Sleep Apnea Screening Study (Not covered by AHC)

In-Clinic Level 1 (Full Polysomnographic) Sleep Study (Not covered by AHC)

Consultation (Covered by AHC)

#### HISTORY AND PHYSICAL INFORMATION

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

#### 1 HISTORY OF SLEEP PROBLEM

Snoring  Nocturia  Restless Legs Syndrome  Cataplexy  
 Witnessed Apneas  Insomnia  Periodic Limb Movement Disorder  Sleepwalking/Nightmares  
 Excessive Daytime Sleepiness  Frequent Awakenings  Shift Work  Other \_\_\_\_\_

#### 2 MEDICAL CONDITIONS

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

#### 3 MEDICATIONS

\_\_\_\_\_  
 \_\_\_\_\_

#### 4 RELEVANT FAMILY / SOCIAL / PERSONAL HISTORY (if request for sleep study only)

\_\_\_\_\_  
 \_\_\_\_\_

#### 5 PHYSICAL EXAM – POSITIVE FINDINGS (if request for sleep study only)

\_\_\_\_\_  
 \_\_\_\_\_

#### + SPECIAL NEEDS (i.e., assistance moving, difficulty communicating)

\_\_\_\_\_  
 \_\_\_\_\_

Physician's signature: \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE CHECK IF YOU WOULD LIKE US TO SEND YOU MORE REFERRAL FORMS.