



SLEEP DISORDER REFERRAL FORM

PLEASE FAX THIS FORM TO: 780-487-3045

PERSONAL INFORMATION

Name _____
AHCIP Number _____
Birth Date _____ Age _____

Height _____ Weight _____ Gender: M F
Home Phone _____
Work Phone _____

REFERRING PHYSICIAN

Physician _____
PRACID # _____
Street Address _____
City _____ Zip/Postal Code _____

Phone _____
Fax _____
Email _____

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

- | | | |
|---|--|--|
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Shift Work |
| <input type="checkbox"/> Witnessed Apneas | <input type="checkbox"/> Frequent Awakenings | <input type="checkbox"/> Cataplexy |
| <input type="checkbox"/> Excessive Daytime Sleepiness | <input type="checkbox"/> Restless Legs Syndrome | <input type="checkbox"/> Sleepwalking/Nightmares |
| <input type="checkbox"/> Nocturia | <input type="checkbox"/> Periodic Limb Movement Disorder | <input type="checkbox"/> Other _____ |

2 MEDICAL CONDITIONS

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

* SLEEP TESTING SERVICES ARE CURRENTLY NOT COVERED BY ALBERTA HEALTH CARE. FOR FURTHER INFORMATION ON FEES PLEASE CONTACT US DIRECTLY.