BRITISH COLUMBIA | Ministry of Health

FORM B: (OPTIONAL) REFERRAL REQUEST – SLEEP DISORDER CONSULTATION

PATIENT INFORMATION (*denotes required field)

Last Name*	First Name*	PHN*

Date of Birth* (YYYY / MM / DD)	Gender	Preferred Language

Primary Contact Number*	Secondary Contact Number	Email

Address

Safety Critical Occupation* – *if Yes, provide detail in Patient History*

◯ Yes ◯ No (e.g. truck, taxi, bus drivers; airline/marine pilots; emergency personel; constructution workers; etc.)

Patient History and Comorbid Conditions

Allergies and Medications

REASON FOR REFERRAL

Reason for Referral

This is an urgent referral ◯ Yes ◯ No (If Yes, provide detail:)

The following patient information is included in this referral:

- ☐ Pertinent patient history/medical notes (including relevant reports from sleep disorder physicians or other practitioners)
- ☐ Recent blood work and lab reports
- ☐ Relevant radiology reports
- ☐ All available sleep studies (HSAT or polysomnogram) and PAP therapy results
- ☐ Other: _____

REFERRING PRACTITIONER

Name*

MSP Number*

Clinic Name

Street Address STAMP

Phone Fax

Primary Care Provider*

◯ Same as Referring Practioner ◯ None

Copy to (full name and Speciality or MSP Number)

SLEEP DISORDER PHYSICIAN / POLYSOMNOGRAPHY FACILITY

See list of accredited polysomnography facilities here:
https://www.cpsbc.ca/files/pdf/DAP-Accredited-Facilities-PS.pdf

Name of Polysomnography Facility / Sleep Disorder Physician

NORTH VANCOUVER SLEEP DISORDERS CLINIC & LABORATORY

Office Location

North Vancouver Sleep Disorders Clinic & Laboratory
Unit 304 - 1200 Lonsdale Ave.
North Vancouver, BC V7M 3H6
Fax 604-973-2236

Phone Number **604-973-2234**

Email Address **referraldesk@vancouversleeplab.com**

REFERRING PRACTITIONER SIGNATURE

Thank you for seeing this patient in consultation.

Please contact patient directly with appointment information and let our office know the approximate wait time.

Should you have any issue communicating with this patient, please let us know.

Referring Practitioner Signature

Date Signed (YYYY / MM / DD)

The personal information collected on this form is collected under the authority of the *Personal Information Protection Act*. The personal information is used to provide medical services requested on this requisition. The information collected is used for quality assurance management and disclosed to healthcare practitioners involved in providing care or when required by law. Personal information is protected from unauthorized use and disclosure in accordance with the *Personal Information Protection Act* and when applicable the *Freedom of Information and Protection of Privacy Act* and may be used and disclosed only as provided by those Acts.