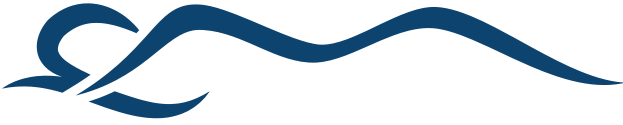
NORTH VANCOUVER SLEEP DISORDERS CLINIC & LABORATORY



www.vancouversleeplab.com

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FAX TO SLEEP LAB INTAKE:
604-973-2236

SLEEP DISORDER REFERRAL FORM

DATE
(MM / DD / YYYY)

PATIENT INFORMATION:

Last Name	First Name	PHN	Date of Birth (MM / DD / YYYY)	Gender

Address	Phone	Mobile

REFERRING PRACTITIONER

Referring Physician Name:	MSP#	Phone	Fax

Clinic Address	Copy to *(full name and/or MSP number)*

PLEASE CHOOSE:

❑ **Level 1 - Laboratory based Polysomnography testing**
(Sleep Disorder Physician Consultation to be performed prior to any in lab testing such as Level 1 Polysomnography, CPAP or Dental titration, MWT, MSLT & other in-lab tests)

❑ **Level 3 - Home Sleep Apnea Test (HSAT) with auto CPAP trial if indicated**
(without Sleep Disorder Physician Consultation)

REASON FOR REFERRAL:

❑ Sleep Apnea
❑ Insomnia
❑ Narcolepsy
❑ Drivers license suspension
❑ REM behaviour disorder
❑ Restless Leg Syndrome
❑ Excessive daytime Sleepiness
❑ Movement Disorder
❑ Parasomnia (ex. sleep walking/sleep talking)
❑ Other: ______________________________

MEDICAL HISTORY:

❑ Hypertension
❑ Obesity
❑ Migraine
❑ Depression
❑ Heart Failure
❑ Hypothyroid
❑ Chronic Pain
❑ Bruxism
❑ CAD/MI
❑ Diabetes
❑ Opioid Rx
❑ ED/Testosterone Rx
❑ Atrial Fibrillation
❑ COPD
❑ Restrictive lung disease
❑ Chronic Fatigue/Fibromyalgia
❑ CVA/TIA
❑ Safety critical occupation
❑ Neuromuscular disease

OTHER MEDICAL HISTORY:	MEDICATIONS:

COMMENTS: ....

If this referral is urgent please explain:

Physician Signature

We will contact the patient directly to book the appointment, and will notify your office of the appointment date for your records. Thank you for your referral.