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# SLEEP DISORDER REFERRAL FORM

☐ **Consult Only** ☐ **Home Sleep Study** ☐ **Sleep Study and Consult**

To: Dr. Sanjive Jain Phone: 905-832-8333 Fax: 905-886-9618

## PATIENT INFORMATION)

Name: _____

DOB: _____ Gender: ☐ F ☐ M

Height: _____ Weight: _____

Address: _____

_____

Phone #: _____

HIN: _____

## REFERRING PHYSICIAN'S INFORMATION

Name: _____

Phone #: _____

Fax #: _____

Address: _____

_____

Billing #: _____

Signature: _____

## SIGNS & SYMPTOMS

☐ Snoring ☐ Insomnia ☐ Frequent Awakenings

☐ Witnessed Apnea ☐ Restless Leg Syndrome ☐ Chronic Fatigue

☐ Excessive Daytime Sleepiness ☐ Periodic Limb Movement Disorder ☐ Shift Work

☐ Morning Headaches ☐ Non-Restorative Sleep ☐ Cataplexy

☐ Sleepwalking/Nightmares Other: _____

## MEDICAL HISTORY

☐ MI / CAD ☐ Asthma ☐ COPD ☐ Skin Problems ☐ Panic Attacks ☐ Arthritis

☐ Hypertension ☐ CHF ☐ Traumatic Brain Injury ☐ Lyme Disease ☐ PTSD ☐ Migraines

☐ MVA Accident ☐ Cancer ☐ Fibromyalgia ☐ Seizures ☐ OCD ☐ IBS

☐ Diabetes ☐ Alcoholism ☐ Chronic Pain ☐ Bruxism ☐ Mood Disorder ☐ GERD

Other: _____

Current Medication: _____

_____

Allergies: ☐ NKA ☐ NKDA _____

## OTHER MEDICAL HISTORY

Is The Patient On Oxygen? ☐ No ☐ Yes L/Minute _____ ☐ Night-time Only ☐ Day and Night

Is The Patient On CPAP? ☐ No ☐ Yes cm $H_2O$ _____

**IMPORTANT: Has the Patient Undergone a Sleep Study Previously?** ☐ No ☐ Yes

If Yes, Please Specify Date Of Sleep Study: _____

Special Needs: ☐ Communication ☐ Hearing ☐ Mobility Other: _____