CENTRE FOR SLEEP
& HUMAN PERFORMANCE

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SELF REFERRAL FORM

(*Once your referral form is submitted, you will be contacted directly for appointments)

SURNAME: _____ **GIVEN NAME(S):** _____ SEX: ☐ M ☐ F

ADDRESS: _____
City Province Postal Code

DATE OF BIRTH: _____ **ALBERTA HEALTH CARE #:** _____
Month (please spell out) Day Year (YYYY)

HOME PHONE: _____ **WORK PHONE:** _____ **CELL PHONE:** _____

EMAIL ADDRESS: _____ **OCCUPATION:** _____

FAMILY PHYSICIAN: _____

HOW DID YOU HEAR ABOUT US?

☐ Website ☐ Facebook/Twitter
☐ Family/Friend ☐ Presentation, specify: _____
☐ Doctor ☐ Other, specify: _____

PRIMARY SLEEP CONCERNS (MANDATORY – Check all that apply):		**ADDITIONAL INFORMATION:**
☐ Obstructive Sleep Apnea (Snoring)	☐ Movement Disorders (e.g., Restless Legs Syndrome)	☐ Safety Sensitive Occupation, specify:
☐ Insomnia (Difficulty falling/staying asleep)	☐ Parasomnia (Abnormal sleep behavior like sleep walking or night terrors), specify:	
☐ Excessive Daytime Sleepiness	☐ Athlete	
☐ Shift Work		

CURRENT MEDICATIONS / ADDITIONAL MEDICAL INFORMATION:	**FOR OFFICE USE ONLY**
	Triage:

Copies of the referral form can also be downloaded from our website at www.centreforsleep.com (under Medical Professionals) and returned by fax or email.

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