CENTRE FOR SLEEP & HUMAN PERFORMANCE

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PATIENT REFERRAL FORM

(*Once your referral form is submitted, patients 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:** _____

REFERRED BY: _____ **MD PRACID:** _____

ADDRESS: _____
City Province Postal Code

PHONE: _____ **FAX:** _____ **FAMILY PHYSICIAN** (if different from Referring Physician): _____

PRIMARY SLEEP CONCERNS (MANDATORY – Check all that apply):

- ☐ Obstructive Sleep Apnea (Snoring)
- ☐ Insomnia (Non-Restorative Sleep)
- ☐ Excessive Daytime Sleepiness (includes Narcolepsy)
- ☐ Shift Work/Jet Lag/Delayed Sleep Phase
- ☐ Athlete

Movement Disorders:

- ☐ Restless Legs Syndrome
- ☐ Periodic Limb Movement Disorder
- ☐ Sleep Bruxism
- ☐ Other, specify:

Parasomnia:

- ☐ Sleepwalking/Night Terrors
- ☐ Violent behavior in sleep
- ☐ Nightmares
- ☐ Other, specify:

ADDITIONAL INFORMATION:

Safety Sensitive Occupation:

- ☐ Professional Driver
- ☐ Airline Pilot/Flight Staff
- ☐ Railroad Engineer/Conductor
- ☐ Emergency First Responder (EMS/Police/Fire)
- ☐ Doctor / Nurse
- ☐ Oilfield Worker
- ☐ Other, specify:

CURRENT MEDICATIONS / ADDITIONAL MEDICAL INFORMATION:

FOR OFFICE USE ONLY

Triage:

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

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