Dr. Charles H. Samuels, Medical Director
Suite 106, 51 Sunpark Drive SE
Calgary, Alberta T2X 3V4
Tel (403) 254-6663 Fax (403) 254-6693
Email: patients@centreforsleep.com

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: _____ **PERSONAL 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 "Book Appointment") and returned by fax or email.

Rev Nov 2017