



fraserhealth

SLEEP LAB REFERRAL ARH



MSXX106223A

Rev: March 2, 2018

Page: 1 of 2

FAX to ARHCC Sleep Lab intake (604-851-4993)

PATIENT INFORMATION:

Patient's Name: _____			Gender: _____
Last	First	Middle	
Date of Birth: _____	PHN: _____	Insurance: _____	
(DD/MM/YYYY)			
Address: _____			
Street	City	Province	Postal Code
Contact Method Primary: _____		Alternate: _____	

REFERRAL INFORMATION:

Priority: <input type="checkbox"/> Routine <input type="checkbox"/> Urgent Date of Referral: _____	Referring Health Care Provider: Name: _____ Title: _____ Source: _____ MSP #: _____ Phone: _____ Fax: _____
	Reason for Referral: _____ _____ Medical Reason for Urgency: _____ _____ Relevant Medical History: _____ _____
Isolation precautions <input type="checkbox"/> Airborne <input type="checkbox"/> Contact <input type="checkbox"/> Droplet	
Referral Clinic: Sleep Lab - ARH Clinic	
Referring Health Care Provider Signature: _____ Date: _____	

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MSXX106223A

Rev: Dec. 10/14

Page: 2 of 2

FAX to ARHCC Sleep Lab intake (604-851-4993)

PATIENT INFORMATION:

Patient's Name: _____ Last First Middle	Gender: _____
Date of Birth: ____/____/____ (DD/MM/YYYY)	PHN: _____ Insurance: _____
Address: _____ Street City Province Postal Code	
Contact Method: Primary: _____	Alternate: _____

PERTINENT HISTORY

Epworth Sleepiness Scale: _____	Date: _____
Home oximetry test results	
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, attach report and specify:	Location: _____ Date: _____
Previous polysomnogram	
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, attach report and specify:	Location : _____ Date: _____
Previous multiple sleep latency test	
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, attach report and specify:	Location: _____ Date: _____
Treatment initiated (e.g. CPAP, Oral Appliance)	Date: _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	

STUDY TYPE:

<input type="checkbox"/> Diagnostic PSG	<input type="checkbox"/> Titration Study	<input type="checkbox"/> Split-Night Study	<input type="checkbox"/> Oral Appliance	<input type="checkbox"/> MSLT	<input type="checkbox"/> MWT
Additional Information: _____					

OTHER INSTRUCTIONS:

<input type="checkbox"/> Oxygen	<input type="checkbox"/> TcCO2 Monitoring
<input type="checkbox"/> Special Needs (specify): _____	

CLINICAL INFORMATION:

<input type="checkbox"/> Obstructive Sleep Apnea	<input type="checkbox"/> Periodic Limb Movement	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Parasomnia	<input type="checkbox"/> Narcolepsy
<input type="checkbox"/> Central Sleep Apnea	<input type="checkbox"/> Non-Restorative Sleep	<input type="checkbox"/> Depression	<input type="checkbox"/> REM Behaviour Disorder	
<input type="checkbox"/> Obesity-Hypoventilation	<input type="checkbox"/> Idiopathic Hypersomnolence	<input type="checkbox"/> Chronic Fatigue	<input type="checkbox"/> Other: _____	

PRIORITY:

<input type="checkbox"/> 1 (URGENT) Patient with: * suspected sleep disorder; and * major daytime disorder sleepiness (ESS 10 or greater); and * one or more of the following: - stable co-morbid disease; or - high risk occupation; or - overnight home oximetry which reveals > 10/hour 4% desaturations	<input type="checkbox"/> 2 Patients with: * suspected sleep disorder; and * major daytime sleepiness (SS 10 or greater); but * no co-morbid disease or high-risk occupation	<input type="checkbox"/> 3 Patients with: * suspected sleep disorder; but without * suspected daytime sleepiness (ie. ESS < 10); or * co-morbid diseases; or * high-risk occupation
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INFORMATION NEEDED PRIOR TO BOOKING:

Please forward copies of any of the following items:	<input type="checkbox"/> Sleep History Consultations
	<input type="checkbox"/> Recent Overnight Oximetry Interpretations
	<input type="checkbox"/> Recent CPAP Titration Downloads

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