



fraserhealth

SLEEP LAB REFERRAL ARH



MSXX106223A

Rev: March 2, 2018

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

PATIENT INFORMATION:

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

REFERRAL INFORMATION:

Priority: <input type="checkbox"/> Routine <input type="checkbox"/> Urgent	Referring Health Care Provider:
Date of Referral: _____	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

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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:** _____

PERTINENT HISTORY

Epworth Sleepiness Scale: _____ **Date:** _____

Home oximetry test results
 Yes No If yes, attach report and specify: _____ **Location:** _____ **Date:** _____

Previous polysomnogram
 Yes No If yes, attach report and specify: _____ **Location :** _____ **Date:** _____

Previous multiple sleep latency test
 Yes No If yes, attach report and specify: _____ **Location:** _____ **Date:** _____

Treatment initiated (e.g. CPAP, Oral Appliance)
 Yes No **Date:** _____

STUDY TYPE:

Diagnostic PSG Titration Study Split-Night Study Oral Appliance MSLT MWT

Additional Information: _____

OTHER INSTRUCTIONS:

Oxygen TcCO₂ Monitoring

Special Needs (specify): _____

CLINICAL INFORMATION:

Obstructive Sleep Apnea Periodic Limb Movement Insomnia Parasomnia Narcolepsy

Central Sleep Apnea Non-Restorative Sleep Depression REM Behaviour Disorder

Obesity-Hypoventilation Idiopathic Hypersomnolence Chronic Fatigue Other: _____

PRIORITY:

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

2 Patients with:
 * suspected sleep disorder; and
 * major daytime sleepiness (SS 10 or greater); but
 * no co-morbid disease or high-risk occupation

3 Patients with:
 * suspected sleep disorder; but without
 * suspected daytime sleepiness (ie. ESS < 10); or
 * co-morbid diseases; or
 * high-risk occupation

INFORMATION NEEDED PRIOR TO BOOKING:

Please forward copies of any of the following items: Sleep History Consultations
 Recent Overnight Oximetry Interpretations
 Recent CPAP Titration Downloads

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