fraserhealth

SLEEP LAB REFERRAL
ARH

FAX to JPOCSC Central Intake (604-953-9701)

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:** _____

REFERRAL INFORMATION:

Priority: ☐ **Routine** ☐ **Urgent**

Referring Health Care Provider:
Name: _____
Title: _____ **Source:** _____
MSP #: _____
Phone: _____ **Fax:** _____

Reason for Referral: _____

Medical Reason for Urgency: _____

Relevant Medical History: _____

Isolation precautions ☐ **Airborne** ☐ **Contact** ☐ **Droplet** ☐ **None**

Interpreter Required ☐ **No** ☐ **Yes** **If yes, specify language** _____

Referral Clinic: Sleep Lab - ARH Clinic

Referring Health Care Provider Signature: _____ **Date:** _____

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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) **Date:**

☐ Yes ☐ No

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