DR. A. BORN, MD, FRCPC
DR. Y. MOLTYANER, MD, FRCPC
DR. A. VANEK, MD, FRCPC

UNIVERSAL Sleep Disorder Clinic
★ ★ ★ ★ ★
2888 Bathurst Street
Toronto, ON M6B 4H6
Phone: 416-256-0600 Fax: 416-256-0602

SLEEP STUDY REFERRAL FORM
PLEASE FAX THIS FORM TO: 416-256-0602

Patient Information

Name _____
OHIP No. _____
D.O.B. _____

Address _____
_____
Phone (Home) _____ (Bus) _____
Cell _____

Referring Physician

Physician _____
Billing No. _____

Address _____
Phone _____ Fax _____

☐ Sleep Study: *If evidence for significant sleep apnea, arrange consultation with a sleep physician.*
☐ Sleep Study only
☐ Consultation only
☐ Sleep Study and Consultation

☐ CPAP Titration *(requires consultation with a sleep physician)*
☐ Did this patient have a previous sleep study in Ontario?
If yes, please fax copies of any available sleep studies and consultations.
If yes, consultation with sleep physician is mandatory according to MOH regulations.

Provisional Diagnosis: _____

Complaints

☐ Snoring
☐ Snoring with Apneas
☐ Unrestorative Sleep
☐ Morning Headache
☐ Daytime Somnolence
☐ Falling Asleep while Driving
☐ Obesity
☐ Drop Attacks or Unexplained Fainting
☐ Difficulty Getting to Sleep
☐ Difficulty Staying Awake
☐ Frequent Awakenings
☐ Abnormal Behaviour During Sleep
☐ Repetitive Leg Movements During Sleep
☐ Feeling of Paralysis

Other, *Please Specify*: _____

Medical History

☐ Angina
☐ Arrhythmia
☐ Hypertension
☐ Stroke
☐ CHF
☐ Pacemaker
☐ Other Cardiac Disease

List Other Significant Medical/Surgical History: _____

_____

_____

Allergies? Please List: _____

Current Medications: _____

_____

_____

Is Patient on: Oxygen _____ L/min CPAP _____ cm/H20

Requesting Physician Signature _____ Date _____