



Referral Type

- ☐ Initial Sleep Study only (first ever sleep study)
- ☐ Initial Sleep Study followed by Consultation if significant abnormality (first ever sleep study)
- ☐ Repeat Sleep Study (sleep physician consultation/assessment prior to study)
- ☐ Consultation only

☐ Snoring ☐ Suspected sleep apnea ☐ Chronic insomnia ☐ Daytime sleepiness
☐ Unexplained fatigue ☐ Non-restorative sleep ☐ Restless legs/Leg movement disorder during sleep
☐ Atrial fibrillation ☐ Congestive heart failure ☐ Other _____
☐ Urgent study required

Patient's Name _____ ☐ M ☐ F
Last name First name

Address _____
Number and Street Name Apt. # City Postal Code

Home Phone _____ Daytime/Work Phone _____ Cell Phone _____

Date of Birth _____ Health Card _____
Day Month Year

Email _____ Relevant Medical Conditions _____

Medications _____

Special Needs ☐ Language ☐ Care Giver Has patient had prior sleep testing? Date _____
Requirements ☐ Ambulation ☐ Care Assistance Location _____

Referring Physician _____	OHIP Billing # _____
Full Name and Initials	
Telephone _____	Fax _____
Address _____	
Number and Street Name	Suite Number
City	Postal Code
Copies to: _____ Email (optional) _____	
Signature _____	

Approved by Sleep Physician _____ Date _____ ☐ Urgent

Special Considerations