Tranq Sleep Care
Neuro Sleep Clinic Kelowna

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# Patient Referral Requisition

### *Part A: Referral Request*

☐ **Consultation/Tele-Consultation**

### *Part A: Patient Information*

Name: ______________________ DOB: ______________ Gender: ☐ Male ☐ Female

Address: ______________________ Phone: ______________ Height: ______________

______________________ PHN: ______________ Weight: ______________

Email: ______________________

### *Part B: Referral Information*

Referral Reason:

☐ Insomnia ☐ Excessive Daytime Sleepiness ☐ Restlessness at night

☐ Witnessed Apnea ☐ Abnormal Prior Sleep Study ☐ Others: ______________________

☐ Narcolepsy ☐ Frequent Nocturnal Awakenings ______________________

Relevant History:

☐ Hypertension ☐ MI (Myocardial Infarction) ☐ Cardiac Arrhythmia ☐ Depression

☐ DM ☐ CAD (Coronary Artery Disease) ☐ Fibromyalgia ☐ Thyroid Dysfunction

☐ Hyperlipidemia ☐ CHF (Congestive Heart Failure) ☐ Atrial Fibrillation ☐ Anxiety Disorder

☐ Stroke ☐ COPD ☐ GERD ☐ Smoking

☐ Chronic Pain ☐ TIA (Transient Ischemic Attack) Others: ______________________

Current Medications:______________________________________________

Allergies/Sensitivities: ______________________________________________

### *Part C: Referring Physician Information*

Physician Name: ______________________ Phone: ______________________

Billing No.: ______________________ Fax: ______________________

Address: ______________________

______________________ Signature: ______________________

### *Part E: Urgency Level*

◯ **Level 1 – patient seen within 4 weeks (Criteria is ESS>10 and co-morbid disease and high-risk occupation, or AHI > 10)**

◯ **Level 2 – patient seen within 8 weeks (Criteria is ESS>10 or AHI > 10)**

◯ **Level 3 – patient seen within 6 months**

**Fax completed requisition to Kelowna Office at 1-250-860-8414 and attach copy of Ferritin level, TSH, B12, Oximetry or Sleep Reports if available.**