



## Patient Referral Requisition

### Part A: Referral Request

Consultation/Tele-Consultation AND Overnight In-Lab Level I Sleep Study

### Part B: Patient Information

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender:  Male  Female  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Height: \_\_\_\_\_  
\_\_\_\_\_ PHN: \_\_\_\_\_ Weight: \_\_\_\_\_  
Email: \_\_\_\_\_

### Part C: 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 D: 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 Northern BC Sleep Center at 1-250-784-0268 and attach copy of Ferritin TSH, B12, Oximetry or Sleep Reports if available.**