



Tranq Sleep Care
Northern BC Sleep Center

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Patient Referral Requisition

Part A: Referral Request

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

☐ Apnea Fast track with Home Level III Study

Part B: Patient Information

Name: _____ DOB: _____ Gender: ☐ Male ☐ Female
Address: _____ Phone: _____ Height: _____
_____ PHN: _____ Weight: _____
Email: _____

Part C: Referral Information

Referral Reason:

- | | | |
|--|--|--|
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Excessive Daytime Sleepiness | <input type="checkbox"/> Restlessness at night |
| <input type="checkbox"/> Witnessed Apnea | <input type="checkbox"/> Abnormal Prior Sleep Study | <input type="checkbox"/> Others: _____ |
| <input type="checkbox"/> Narcolepsy | <input type="checkbox"/> Frequent Nocturnal Awakenings | _____ |

Relevant History:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> MI (Myocardial Infarction) | <input type="checkbox"/> Cardiac Arrhythmia | <input type="checkbox"/> Depression |
| <input type="checkbox"/> DM | <input type="checkbox"/> CAD (Coronary Artery Disease) | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Thyroid Dysfunction |
| <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> CHF (Congestive Heart Failure) | <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Anxiety Disorder |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> COPD | <input type="checkbox"/> GERD | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> 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.