Tranq Sleep Care
Richmond Sleep Center

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Patient Referral Requisition

Part A: Referral Request

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

☐ **Apnea Fast track with Home Level III Study (Ministry recommends the use of Form A when requesting for HSAT)**
https://www2.gov.bc.ca/assets/gov/health/forms/1944fil.pdf

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 Richmond Sleep Center Office at 1-604-564-0179 and attach copy of Ferritin level, TSH, B12, Oximetry or Sleep Reports if available.