



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:

- 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 Williams Lake Office at 1-778-412-9323 and attach copy of Ferritin level, TSH, B12, Oximetry or Sleep Reports if available.