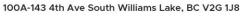


## Tranq Sleep Care Williams Lake Sleep Center

Dr. Wayne W. Lai Inc. MSP #64654



Tel: 778-412-9321 Fax: 778-412-9323



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## **Patient Referral Requisition**

Part A: Referral Requ	uest					
<ul> <li>□ Consultation/Tele-Consultation AND</li> <li>Overnight In-Lab Level I Sleep Study</li> </ul>		☐ Apnea Fast track with Home Level III Study				
Part B: Patient Inform	mation					
Name:		DOB: _		Gender:	☐ Male	☐ Female
		Phone:		_		
		PHN: _		Weight:		
Part C: Referral Info						
Referral Reason:						
<ul><li>☐ Insomnia</li><li>☐ Witnessed Apnea</li><li>☐ Narcolepsy</li></ul>	<ul><li>☐ Excessive Daytime Sleepiness</li><li>☐ Abnormal Prior Sleep Study</li><li>☐ Frequent Nocturnal Awakening</li></ul>	S	☐ Restlessness at night ☐ Others:			
Relevant History:						
<ul><li>☐ Hypertension</li><li>☐ DM</li><li>☐ Hyperlipidemia</li><li>☐ Stroke</li><li>☐ Chronic Pain</li></ul>	<ul> <li>☐ MI (Myocardial Infarction)</li> <li>☐ CAD (Coronary Artery Disease)</li> <li>☐ CHF (Congestive Heart Failure)</li> <li>☐ COPD</li> <li>☐ TIA (Transient Ischemic Attack)</li> </ul>		<ul><li>☐ Cardiac Arrhythmia</li><li>☐ Fibromyalgia</li><li>☐ Atrial Fibrillation</li><li>☐ GERD</li><li>Others:</li></ul>	<ul><li>□ Depression</li><li>□ Thyroid Dysfunction</li><li>□ Anxiety Disorder</li><li>□ Smoking</li></ul>		ysfunction isorder
Part D: Referring Ph	ysician Information					
Billing No.:			Phone: Fax: Signature:			
Part E: Urgency Leve	el					
O Level 2 – patient se	een within 4 weeks (Criteria is ESS>1 een within 8 weeks (Criteria is ESS>1 een within 6 months		_	n-risk occi	upation, or A	HI > 10)

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.