

PATIENT REFERRAL FORM

(*Once your referral form is submitted, patients will be contacted directly for appointments)

SURNAME: _____		GIVEN NAME(S): _____		SEX: <input type="checkbox"/> M <input type="checkbox"/> F	
ADDRESS: _____					
		City	Province	Postal Code	
DATE OF BIRTH: _____			ALBERTA HEALTH CARE #: _____		
		Month (please spell out)	Day	Year (YYYY)	
HOME PHONE: _____		WORK PHONE: _____		CELL PHONE: _____	
EMAIL ADDRESS: _____			OCCUPATION: _____		

REFERRED BY: _____		MD PRACID: _____			
ADDRESS: _____					
		City	Province	Postal Code	
PHONE: _____		FAX: _____		FAMILY PHYSICIAN (if different from Referring Physician): _____	

PRIMARY SLEEP CONCERNS (MANDATORY – Check all that apply):	ADDITIONAL INFORMATION:
<input type="checkbox"/> Obstructive Sleep Apnea (Snoring) <input type="checkbox"/> Insomnia (Non-Restorative Sleep) <input type="checkbox"/> Excessive Daytime Sleepiness (includes Narcolepsy) <input type="checkbox"/> Shift Work/Jet Lag/Delayed Sleep Phase <input type="checkbox"/> Athlete	Safety Sensitive Occupation: <input type="checkbox"/> Professional Driver <input type="checkbox"/> Airline Pilot/Flight Staff <input type="checkbox"/> Railroad Engineer/Conductor <input type="checkbox"/> Emergency First Responder (EMS/Police/Fire) <input type="checkbox"/> Doctor / Nurse <input type="checkbox"/> Oilfield Worker <input type="checkbox"/> Other, specify: _____
Movement Disorders: <input type="checkbox"/> Restless Legs Syndrome <input type="checkbox"/> Periodic Limb Movement Disorder <input type="checkbox"/> Sleep Bruxism <input type="checkbox"/> Other, specify: _____	
Parasomnia: <input type="checkbox"/> Sleepwalking/Night Terrors <input type="checkbox"/> Violent behavior in sleep <input type="checkbox"/> Nightmares <input type="checkbox"/> Other, specify: _____	

CURRENT MEDICATIONS / ADDITIONAL MEDICAL INFORMATION:	FOR OFFICE USE ONLY
	Triage: