sleepandwake clinic

P: 1-403-474-0800 F: 1 403-474-0837

CONSULTATION REQUEST

Name: ______________________ DOB: ___/___/_____ Age: _________ Gender: ☐ M ☐ F

Address: ______________________ City: ____________ Province: ______ Postal Code: ________

Phone: ______________ Email: ______________________ PHN: ____________

Type of referral

Reason for Referral	Consultation Services	Technical Services
☐ Routine	☐ Sleep Medicine	☐ Ambulatory Sleep Study
☐ Urgent	☐ Psychiatry (Explain below)	☐ In-Lab Sleep Study – requires consultation

Primary Sleep Concerns (Mandatory – Check all that apply)

	Movement Disorders	Parasomnia
☐ Obstructive Sleep Apnea (Snoring)	☐ Restless Legs Syndrome	☐ Sleepwalking/Night Terrors
☐ Insomnia (Non Restorative Sleep)	☐ Periodic Limb Movement Disorder	☐ Violent Sleep Behaviours
☐ Excessive Daytime Sleepiness (Includes Narcolepsy)	☐ Sleep Bruxism	☐ Nightmares
☐ Shift Work/Jet Lag/Delayed Sleep Phase	☐ Other, specify: ____________	☐ Other, specify: ____________
☐ Fatigue/Non-Restorative Sleep		
☐ Sleep-Related Behaviour		

Additional Information (Safety Sensitive Occupation)

☐ Professional Driver	☐ Airline Pilot/Flight Staff	☐ Railroad Engineer/Conductor
☐ Emergency First Responder (EMS/Police/Fire)	☐ Doctor/Nurse	☐ Oilfield Worker
☐ Other, specify: ____________		

Pertinent Labs or Physical Findings

Past Medical History

Current Medications

Additional Information

Referring Provider: ______________________ Prac. ID: ______________________

Phone Number: ______________________ Fax No.: ______________________

Please attach any other pertinent clinical information

Thank you