London Health Sciences Centre

Sleep & Apnea Assessment Unit
A. Kashgari MBBS, FRCPC
Medical Director

REFERRAL

Date (YYYY/MM/DD): _____

Telephone 519-667-6855 / Fax 519-667-6715

Please note that patients may be scheduled directly into the sleep laboratory at the discretion of the laboratory physician depending upon clinical circumstances. The clinical information is mandatory. If the referral is not fully completed, it will be returned to you without an appointment and this patient will need to be re-referred.

Patient Information (All fields required)

PIN: _____

Name _____

DOB (YYYY/MM/DD) _____

Current Address _____

City _____ Postal Code _____

Home ( ) _____ Work ( ) _____

Health Card _____ Version Code _____

Email _____

Referring Physician Information (All fields required)

Name _____

Current Address _____

City _____ Postal Code _____

Phone ( ) _____ Fax ( ) _____

OHIP REFERRAL # _____

Physician's Signature:

Family Physician _____

Prior sleep study done? ☐ Yes ☐ No If Yes, where was it done? ☐ LHSC ☐ Other (Please provide copy)

Reason For Referral:

☐ Snoring ☐ Sleep Apnea ☐ Narcolepsy ☐ Insomnia ☐ Excessive Daytime Sleepiness

☐ Re-assessment ☐ Other _____

Please check (✓):

☐ Professional driver ☐ Currently using CPAP/BiPAP ☐ PaCO2 ≥ 45

☐ Prefers day sleep study (night shift worker) *(attach supporting information)*

Allergies (drug, food, environmental, latex, etc.):

_____

Contact Precautions:

☐ **MRSA** ☐ **C. Difficile (Active)**

Relevant Medical History:

_____

_____

_____

MUST Complete

Medications: Please attach list

Height: _____ cm **Weight:** _____ kg

STOP-Bang score: _____ Epworth Sleepiness score: _____

Sleep Physician Requested:

☐ M. Sen ☐ J. Barr ☐ A. Kashgari ☐ H. Racz ☐ W. Reisman ☐ No Preference

OFFICE USE ONLY

Previous Lab: _____ **Previous Clinic:** _____

AHI: _____ _____

_____ _____

☐ R/O OSA ☐ Split Night ☐ ASV ☐ Video Record

☐ May Split ☐ BiPAP_____ ☐ Repeat ☐ Sleep Logs ☐ TcCO2

☐ CPAP_____ ☐ Post-op_____ ☐ Clinic New/Fup _____ ☐ Other: _____

Appointment Date:

Lab: _____ Clinic: _____

☐ Mail _____ ☐ Fax _____ ☐ Email _____ E S