

BURLINGTON SLEEP MEDICINE CENTRE

809 Brant Street, Suite 2, Burlington, Ontario L7R 2J4

www.sleepawake.com

**Medical Director: Dr. H. Awad, M.D., F.R.C.P.C, M.R.C.Psych. (UK), Dip. A.B.S.M., F.A.A.S.M.
Dr. R. Haddon, MB., F.R.C.P.C.**

Office: (905) 338-3331 Lab: (905) 632-9015 Fax: (905) 338-2923

SLEEP STUDY REFERRAL

Date of Referral: _____
Referring Doctor: _____ Physician No.: _____
Telephone: _____ Fax No.: _____
Patient Surname: _____ Given Name: _____
Date of Birth (dd/mm/yyyy): _____ Male _____ Female
Address: _____
Home Telephone: _____ Business Telephone: _____
Health No.: _____ Version Code: _____

PURPOSE OF SLEEP STUDY: Diagnosis Treatment Investigation & Treatment as necessary

COMPLAINTS

- | | |
|--|---|
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Disturbed, Restless Sleep |
| <input type="checkbox"/> Snoring with Apnea | <input type="checkbox"/> Non-Restorative Sleep |
| <input type="checkbox"/> Recurrent Headaches | <input type="checkbox"/> Leg Jerks, Restless Legs |
| <input type="checkbox"/> Daytime Fatigue, Excessive Daytime Sleepiness | <input type="checkbox"/> Sleep Walking, Talking, Violent Behaviour at Night |
| <input type="checkbox"/> Other (Specify): _____ | |

PROVISIONAL DIAGNOSIS

- | | |
|---|---|
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Restless Legs Syndrome | <input type="checkbox"/> Periodic Limb Movements Disorder |
| <input type="checkbox"/> Idiopathic Hypersomnia | <input type="checkbox"/> Narcolepsy |
| <input type="checkbox"/> Other (Specify): _____ | |

MEDICAL & SURGICAL HISTORY: _____

CURRENT MEDICATIONS: _____

SIGNATURE OF REFERRING PHYSICIAN: _____

Scoring, interpretation of the study and clinical evaluation of patients are all completed on site.

Please contact the office at (905) 338-3331 to book appointment or fax this form to (905) 338-2923 and we will be in contact soon.

Please advise patient that there will be two appointments booked for them. Thank you.