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Pure Flow HEALTHCARE
The essence of genuine care™

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SLEEP DISORDER REFERRAL FORM

☐ **Sleep Study Only** ☐ **Consult Only** ☐ **Sleep Study and Consult (only if abnormal)**

Please fill in all information and fax to our office. Patients will be contacted directly. **Fax: 1-888-501-9616**

PATIENT INFORMATION (PATIENT LABEL)

Name: _____

DOB: _____ Gender: ☐ F ☐ M

Height: _____ Weight: _____

Address: _____

_____

Phone #: _____

HIN: _____

REFERRING PHYSICIAN'S INFORMATION

Name: _____

Phone #: _____

Fax #: _____

Address: _____

_____

Billing #: _____

Signature: _____

SIGNS & SYMPTOMS

☐ Snoring	☐ Insomnia	☐ Frequent Awakenings
☐ Witnessed Apnea	☐ Restless Leg Syndrome	☐ Chronic Fatigue
☐ Excessive Daytime Sleepiness	☐ Periodic Limb Movement Disorder	☐ Shift Work
☐ Morning Headaches	☐ Non-Restorative Sleep	☐ Cataplexy
☐ Sleepwalking/Nightmares	Other: _____	

MEDICAL HISTORY

☐ MI / CAD	☐ Asthma	☐ COPD	☐ Skin Problems	☐ Panic Attacks	☐ Arthritis
☐ Hypertension	☐ CHF	☐ Traumatic Brain Injury	☐ Lyme Disease	☐ PTSD	☐ Migraines
☐ MVA Accident	☐ Cancer	☐ Fibromyalgia	☐ Seizures	☐ OCD	☐ IBS
☐ Diabetes	☐ Alcoholism	☐ Chronic Pain	☐ Bruxism	☐ Mood Disorder	☐ GERD

Other: _____

Current Medication: _____

_____

Allergies: ☐ NKA ☐ NKDA _____

OTHER MEDICAL HISTORY

Is The Patient On Oxygen? ☐ No ☐ Yes L/Minute _____ ☐ Night-time Only ☐ Day and Night

Is The Patient On CPAP? ☐ No ☐ Yes cm H_2O _____

IMPORTANT: Has the Patient Undergone a Sleep Study Previously? ☐ No ☐ Yes

If Yes, Please Specify Date Of Sleep Study: _____

Special Needs: ☐ Communication ☐ Hearing ☐ Mobility Other: _____

OFFICE USE ONLY: Date Received: _____ Appointment Date: _____