Appleton Clinic

Medical Director: Dr. Darryl Appleton, M.D., FRCP(C)
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Sleep Disorders Center Referral Form

Patient's Information (print or patient's sticker if available):

**Patient's Last Name _____ First _____ Date_____

**OHIP _____Version Code _____ ◯ Non-OHIP DOB (D/M/Y)_____/_____ /_____

Sex _____ Has patient had any sleep studies in the past 24mths? _____ If yes, how many & when? _____ Fax Us a Copy

Address_____

**Home Number (____)_____ Cell Number (_____)_____ Bus Number (_____)_____

Email _____ Emergency Contact_____

****Referring Physician (print or physician's stamp if available):**

Name_____ Billing Number _____ Address _____

Signature_____ Tel Number (____)_____ Fax Number (____)_____

****Service Requested:** ◯ Sleep Consultation & Sleep Study ◯ Sleep Study Only ◯ Sleep Consultation

****Study Requested:** ◯ PSG (Polysomnogram) / CPAP/Bi-level Titration Study (if applicable) ◯ Split-Night Study
◯ MSLT ◯ MWT ◯ Other_____

****Sleep Study Eligibility: (Please check at least one -** check all that apply**)**

- ◯ Snoring with chocking / gasping or witnessed apnea episodes during sleep (R/O OSA)
- ◯ Pre-Surgical Assessment to R/O Sleep Apnea ◯ Urgent Booking (Date Needed _____)
- ◯ Abnormal sleep behaviors with violent episodes during sleep with EEG completed and normal (R/O PARASOMNIA)
- ◯ Excessive daytime sleepiness with involuntary muscle weakness or night-time hallucinations (R/O NARCOLEPSY)
- ◯ Periodic leg movements at night with excessive daytime sleepiness (R/O PLMD)
- ◯ Long term excessive daytime sleepiness without symptoms of apnea (R/O IDIOPATHIC HPYERSOMNIA)
- ◯ Re-evaluation of a previous negative diagnostic sleep study with symptom progression (REPEAT DIAGNOSTIC PSG)
- ◯ Establishing therapy for sleep related breathing disorders (INITIAL CPAP, BiPAP, or ASV TITRATION STUDY)
- ◯ Monitoring or adjusting therapy for sleep related breathing disorders (REPEAT CPAP, BiPAP, or ASV TITRATION STUDY)

Other Applicable Sleep Related Complaints: (Check any or all that apply)

- O Insomnia
- O Excessive Daytime Sleepiness
- O Frequent Arousals at night
- O Chronic Pain
- O Unrefreshing Sleep
- O Snoring
- O Restless Legs
- O Leg Kicking
- O Chronic Fatigue
- O Fibromyalgia
- O Migraines/Headaches
- O Seizure Disorder
- O TBI
- O Nightmares
- O Racing Thoughts
- O Circadian Rhythm Disorder
- O Lyme Disease
- O Sleep Walking
- O Sleep Talking
- O Sleep Eating
- O Shift Work
- O Other issues:_____

Current Medications _____

Medical Conditions _____ (Please send copy of recent medical note if available)

Allergies: ◯ NKDA or _____

Does patient have special needs? ◯ Yes Explain _____

Is the patient on Oxygen? ◯ No ◯ Yes _____ L / M _____

**** Mandatory fields, please fill out. (Please advise patients Appleton Clinic is a fragrance FREE environment.)**

Office Use: Sleep Physician agrees with appropriateness of Sleep Study (Stamp/Sign):