



Capital Health

Sleep Disorder Program

Referral Form

SLEEP DISORDERS CLINIC

QEII Health Sciences Centre

Rm. 4008, Abbie J. Lane Bldg.

5909 Veterans Memorial Lane, Halifax, NS B3H 2E2

Ph: (902) 473-4298 Fax: (902) 4737158

REFERRAL FORM

Date of Referral: _____

Consultant Requested: _____ Patient's HC#: _____

Surname: _____ 1st Name: _____ Middle Name: _____

Address: _____ Postal Code: _____

DOB: _____ Telephone: (h) _____ (w) _____ (cell) _____

Referring Doctor: _____ Telephone: _____ Fax: _____

Family Doctor: _____

Reason for Referral: _____

Other Illness/Problems that could Impact on Triage Urgency: i.e. uncontrolled hypertension, chronic respiratory failure, dangerous level of somnolence. ☐ Please check if Public Safety an issue, ie. pilot, air traffic controller, truck driver, etc.

Investigations & consults to date (copies of same) _____

Current Medications/Treatments: _____

**** FULL COMPLETION OF THIS FORM IS NECESSARY FOR TRIAGING ****



Polysomnography Requisition

Date of Referral (YYYY/MM/DD): ____/____/____

☐ Cancellation List ☐ Urgent (ASAP) ☐ Semi-urgent (1-3 months) ☐ Routine

History: _____

Physical Exam:

Height _____ Weight _____ BMI _____ O₂Sat _____

Study Type:

☐ Diagnostic PSG ☐ Split PSG as indicated
☐ CPAP titration instructions: _____
☐ BiPAP titration instructions: _____
☐ ASV titration (LV Ejection Fraction: ____%)
☐ PSG/MSLT ☐ PSG/MWT
☐ Nap study ☐ Other: _____

Provisional Diagnosis:

☐ SDB ☐ Obstructive ☐ Central ☐ CSR ☐ Hypoventilation
☐ Narcolepsy/ Hypersomnia ☐ PLMS ☐ Parasomnia
☐ Other: _____

Medications: _____

Special Requirements:

☐ Oxygen: Level _____ ☐ TcCO₂ ☐ Tidal volumes
☐ Attendant required ☐ Commode ☐ Urinal ☐ Hoyer lift Mobility concerns:
☐ Mask fit ☐ Desensitization ☐ Audio/Video recording Allergy: ☐ Silicone ☐ Latex
☐ Sleep Logs ☐ Other: _____

Usual Bedtime: _____ Usual Waketime: _____

Referring Physician: _____ Physician Signature: _____

Copies to: _____

Requisition Received: _____ Study Date booked: _____





Capital Health

Sleep Disorders Clinic and Laboratory

Booking Form

Date _____ HUN _____
(YYYY/MM/DD)

Patient _____

DOB _____

Physician _____

Referring Physician _____

PFT <input type="checkbox"/> Pre Bronchodilator Spirometry (1) <input type="checkbox"/> Post Bronchodilator Spirometry (2) <input type="checkbox"/> Post Bronchodilator Spirometry only (3) <input type="checkbox"/> Diffusing Capacity (4) <input type="checkbox"/> Lung volumes/Plethysm (5) <input type="checkbox"/> MIPs & MEPS (PI/PE) (6) <input type="checkbox"/> Methacholine (7) <input type="checkbox"/> O ₂ Saturation (8) <input type="checkbox"/> Clinic Spirometry (9) <input type="checkbox"/> ABG's on room air (10) <input type="checkbox"/> ABG's on oxygen (11)	<input type="checkbox"/> Urgent, ASAP <input type="checkbox"/> Next available <input type="checkbox"/> Prior to clinic appt. <input type="checkbox"/> Day of appt. <input type="checkbox"/> Copy of prev. PFT needed _____ _____ _____ _____	Diagnosis: _____ Special Instructions: _____
<input type="checkbox"/> 6 minute walk test on room air (12) <input type="checkbox"/> 6 minute walk test on oxygen (13) <input type="checkbox"/> EST (invasive) (14) <input type="checkbox"/> EST (non-invasive) (15) ___ Treadmill ___ Bike ___ EIA	<input type="checkbox"/> Next available <input type="checkbox"/> Prior to clinic <input type="checkbox"/> Day of appt. <input type="checkbox"/> After clinic appt. _____ _____ _____	
Diagnostic Imaging <input type="checkbox"/> CXR <input type="checkbox"/> CT scan <input type="checkbox"/> _____	<input type="checkbox"/> Prior to clinic appt. <input type="checkbox"/> Day of appt. <input type="checkbox"/> Next available <input type="checkbox"/> _____	
Other <input type="checkbox"/> Allergy Skin Test <input type="checkbox"/> Asthma Education <input type="checkbox"/> Bloodwork <input type="checkbox"/> _____ _____	When _____ _____ _____ _____ _____	Sleep <input type="checkbox"/> Sleep Questionnaire <input type="checkbox"/> Sleep Logs <input type="checkbox"/> PSG <input type="checkbox"/> Level III <input type="checkbox"/> Auto PAP <input type="checkbox"/> Tech Visit <input type="checkbox"/> Drive Fit Letter <input type="checkbox"/> Collect Home Study Records <input type="checkbox"/> Other _____
Patient Type <input type="checkbox"/> New / Urgent (C1) <input type="checkbox"/> New / Rapid (C2) <input type="checkbox"/> New / Next available (C3) <input type="checkbox"/> Return <input type="checkbox"/> Discharge	Clinic Type <input type="checkbox"/> Rapid <input type="checkbox"/> Respiriology <input type="checkbox"/> Sleep <input type="checkbox"/> Pulmonary Rehab <input type="checkbox"/> Book in _____	

Physician's signature: _____

PFT Appointment date: _____

Clinic Appointment date: _____

Booked by: _____

Date: _____

Patient notified by: _____

Date: _____

by phone () mail () fax ()