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: ____

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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.**

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____

Investigations & consults to date (copies of same) ____________________

____

____

Current Medications/Treatments: ____________________

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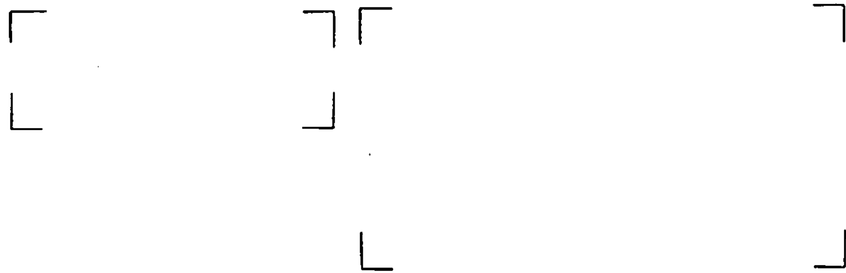
**** FULL COMPLETION OF THIS FORM IS NECESSARY FOR TRIAGING ****

nova scotia health authority



Polysomnography Requisition

Date of Referral (YYYY/MM/DD):________/_____/_____

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

History: ______________________________

Physical Exam:

Height_______ Weight_______ BMI_______ O_2Sat_______

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________ □ $TcCO_2$ □ 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:_________________

Ambulatory Care Reports

CD1003MR_12_2015

Capital Health

Sleep Disorders Clinic and Laboratory

Booking Form

Date ____________________ HUN ____________________
(YYYY/MM/DD)

Patient ____________________ DOB ____________________

Physician ____________________ Referring Physician ____________________

PFT ☐ Pre Bronchodilator Spirometry (1) ☐ Post Bronchodilator Spirometry (2) ☐ Post Bronchodilator Spirometry only (3) ☐ Diffusing Capacity (4) ☐ Lung volumes/Plethysm (5) ☐ MIPS & MEPS (PI/PE) (6) ☐ Methacholine (7) ☐ O_2 Saturation (8) ☐ Clinic Spirometry (9) ☐ ABG's on room air (10) ☐ ABG's on oxygen (11)	☐ Urgent, ASAP ☐ Next available ☐ Prior to clinic appt. ☐ Day of appt. ☐ Copy of prev. PFT needed ____________ ____________ ____________ ____________	**Diagnosis:** ____________ **Special Instructions:**
☐ 6 minute walk test on room air (12) ☐ 6 minute walk test on oxygen (13) ☐ EST (invasive) (14) ☐ EST (non-invasive) (15) ___ Treadmill ___ Bike ___ EIA	☐ Next available ☐ Prior to clinic ☐ Day of appt. ☐ After clinic appt. ____________ ____________	
Diagnostic Imaging ☐ CXR ☐ CT scan ☐ ____________	☐ Prior to clinic appt. ☐ Day of appt. ☐ Next available ☐ ____________	
Other ☐ Allergy Skin Test ☐ Asthma Education ☐ Bloodwork ☐ ____________ ____________	**When** ____________ ____________ ____________ ____________ ____________	**Sleep** ☐ Sleep Questionnaire ☐ Sleep Logs ☐ PSG ☐ Level III ☐ Auto PAP ☐ Tech Visit ☐ Drive Fit Letter ☐ Collect Home Study Records ☐ Other ____________
Patient Type ☐ New / Urgent (C1) ☐ New / Rapid (C2) ☐ New / Next available (C3) ☐ Return ☐ Discharge	**Clinic Type** ☐ Rapid ☐ Respirology ☐ Sleep ☐ Pulmonary Rehab ☐ Book in ________	

Physician's signature: ____________________

PFT Appointment date: ____________________

Clinic Appointment date: ____________________

Booked by: ____________________ Date: ____________

Patient notified by: ____________________ Date: ____________ by phone ( ) mail ( ) fax ( )

CD2423_08_11