Patient Name: _____
Date of Birth: _____ (YYYY/MON/DD)
Health card #: _____
Patient Phone: _____

REQUEST FOR CONSULT/SERVICE FORM
SLEEP DISORDERS PROGRAM

Please complete form with client/patient and fax to 902-473-7158 or email to: sleeplabcz@nshealth.ca.

INFORMATION FOR YOUR CLIENT/PATIENT:

- Please ensure for client/patient is aware of that the referral is being made.
- **Sleep Disorders Program** will attempt to contact client/patient and leave a voicemail, when consent is provided. If patient cannot be reached. The referring provider will be notified. Note the number will appear as Nova Scotia Health (NSH).
- Given NSH facilities are teaching institutions, your client/patient can expect to have residents or students involved in their care.

Date of referral (YYYY/MON/DD): _____

Service Requested:
❑ **Consult**
❑ **Sleep Study**

Please carefully review our inclusion and exclusion criteria below.

Inclusion Criteria	**Exclusion Criteria**
• Suspected sleep disorder	• Nil
CLIENT/PATIENT INFORMATION	**REFERRING PROVIDER INFORMATION**
Legal Name: Preferred name: Pronouns: Parent/Guardian: Phone Number: Full Address: Date of Birth (YYYY/MON/DD): Health Card #: Expiry date:	Referring provider: Phone Number: Full Address: Fax: **If applicable (e.g., trainees, residents)*, Name of supervisor:_____

Are you providing regular follow-up to this patient?
☐ No – Name & contact information for the clinician providing regular follow-up:_____
☐ Yes – Date of next appointment:_____

Is there a need for an interpreter? ❑ Yes ❑ No If yes, please specify which language:
Are there any accessibility concerns? ❑ Yes ❑ No If yes, please specify:

CONSENT TO CONTACT CLIENT/PATIENT/DELEGATE:

By confirming the information below, the referral source confirms that the client/patient gives their consent for the NSH **Sleep Disorders Program** to contact them regarding this referral.
❑ Patient/Client ❑ Delegate ❑ If Delegate, specify relationship to patient:
Consent to leave voicemail message at primary phone number (listed above): ❑Yes ❑ No
Consent to mail letters to address above: ❑Yes ❑ No
If there is an additional phone number to contact, please specify type (e.g., office, cell, etc.) and number:
Consent to leave voicemail at second contact number: ❑Yes ❑ No
Consent to communicate via email: ❑Yes ❑ No Email address: _____

REASONS FOR REFERRAL:

Reason for referral (If urgent/semi-urgent please indicate reason):
_____
Timing of referral: ❑Urgent ❑ Semi-urgent ❑ Routine Final triage to be determined by sleep clinician.
Previous sleep study? ❑ Yes ❑ No
If yes, where and when (month and year)? _____

REQUEST FOR CONSULT/SERVICE FORM
SLEEP DISORDERS PROGRAM

Patient Name: _____
Date of Birth: _____ (YYYY/MON/DD)
Health card #: _____
Patient Phone: _____

Working Diagnosis: _____

CLINICAL SIGNS/HISTORY AFFECTING TRIAGE:

❑ Pilot/Commercial Driver/Air Traffic Controller/Machine Operator ❑ Cataplexy/Narcolepsy
❑ Motor vehicle accident/sleepy driver ❑ Severe Insomnia ❑ Respiratory failure ❑ neuromuscular disease
❑ Uncontrolled Hypertension ❑ Suspected hypoventilation or central apnea ❑ Chronic opioid use ❑ Stroke
❑ Congestive Heart Failure - EF%: _____ Date:
❑ Other (Please specify):
Medications (Please list or attach): _____

Patient has received information about the program: ■ No ☐ Yes

To improve access to care we are offering cancellation lists to patients available on short notice.

❑ **Please add client/patient to cancellation list.**

Completed By: **Date Completed:**

_____ _____ _____
(Please print name and credentials) **Referring Clinician Signature** **(YYYY/MON/DD)**

If your client/patient is at immediate risk of harming themselves or others, the client/patient should be directed to the nearest Emergency Department for assessment. Please ensure all patients are provided with the 24 / 7 provincial Crisis Line (1−888−429−8167) and Emergency resource information.

Please include the following (if possible):

- Relevant lab and test results
- Medication sheet
- Previous psychiatric consultations or discharge summaries
- Medical reports, physical findings and / or psychological findings.

REFERAL MAY NOT BE ACCEPTED IF INCOMPLETE OR ILLEGIBLE.

REQUEST FOR CONSULT/SERVICE FORM
SLEEP DISORDERS PROGRAM