Sleep Disorder Referral Form

FOUND ON MOST EMR SYSTEMS AND DOWNLOADABLE AT **WWW.SLEEPTHERAPEUTICS.CA**

PATIENT INFORMATION:

Last Name: _____ First Name: _____

Address: _____

City: _____ Phone: _____

PHN#: _____ DOB: mm/dd/yyyy _____

SLEEP APNEA TESTING AND TREATMENT OPTIONS

- ☐ Level III / PAT Sleep Study, CPAP/APAP/Bilevel therapy if indicated
- ☐ Sleep Consult, Level III / PAT sleep study only
- ☐ Existing CPAP/APAP patient requiring follow-up

ADDITIONAL OPTIONS

- ☐ Positional Therapy
- ☐ Existing CPAP patient requiring follow up care
- ☐ CBT for Primary Insomnia

PATIENT COMORBIDITIES

- ☐ Anxiety/Depression
- ☐ Hypertension
- ☐ Type 2 Diabetes
- ☐ AFIB

Additional information / Special instructions / Potential contraindications

CLINIC INFORMATION

Physician Name (Print): _____

Signature: _____

Phone: _____ Fax: _____

Date: _____

Clinic Stamp:

Fax Referral To:

Halifax Clinic
Fax: 902.446.3495
Phone: 902.446.3556

Lr. Sackville Clinic
Fax: 902.864.7934
Phone: 902.864.6076

Amherst Clinic
Fax: 902.660.3402
Phone: 902.660.3401

Bedford Clinic
Fax: 902.701.4419
Phone: 902.832.9189

Charlottetown Clinic
Fax: 902.482.2355
Phone: 902.628.0101

Dartmouth Clinic
Fax: 902.469.0401
Phone: 902.469.2550

Middleton Clinic
Fax: 902.363.3036
Phone: 902.363.3035

Bridgewater Clinic
Fax: 902.527.2113
Phone: 902.527.2333

New Minas Clinic
Fax: 902.915.7779
Phone: 902.681.3230

Truro Clinic
Fax: 902.895.2477
Phone: 902.895.9357

SLEEP-SAFR SCREENER

Section A: Previous history of sleep apnea or CPAP Therapy

- ☐ Patient has been previously tested and/or has been diagnosed with sleep apnea
- ☐ Patient has been previously tested with a mild result. Repeat sleep study for insurance
- ☐ Patient previously on CPAP therapy - discontinued therapy

If any boxes are checked, a sleep study is recommended

Section B: Comorbidities

Patient has been diagnosed and/or is being treated for:
(check all that apply)

- ☐ Hypertension
- ☐ Type 2 Diabetes
- ☐ AFIB

If any boxes are checked, a sleep study is recommended

Section C:

- ☐ Family History of Sleep Apnea
- ☐ Snoring indicated
- ☐ Patient wants CPAP for snoring

If any TWO boxes are checked, a sleep study is recommended

Section D:

Category 1 - questions 1-4

2 or more positive answers in this category = positive category. Positive answers are shaded/highlighted.

1. Do you snore? ☐ Yes ☐ No ☐ Don't know

If you snore:

2. Your snoring is:

- ☐ Slightly louder than breathing
- ☐ As loud as talking
- ☐ Louder than talking
- ☐ Very loud. Can be heard in adjacent rooms

3. How often do you snore?

- ☐ Nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ Never or nearly never

4. Has your snoring bothered other people?

- ☐ Yes
- ☐ No

Category 2 - questions 5-8

2 or more positive answers in this category = positive category. Positive answers are shaded/highlighted.

5. Has anyone noticed that you quit breathing in your sleep?

- ☐ Nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ Never or nearly never

6. How often do you feel tired or fatigued after your sleep?

- ☐ Nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ Never or nearly never

7. During your wake time, do you feel tired, fatigued, or not wake up to par?

- ☐ Nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ Never or nearly never

8. Have you ever nodded off or fallen asleep while driving a vehicle?

☐ Yes ☐ No **If yes, how often does this occur?**

- ☐ Nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ Never or nearly never

Sleep Study Evaluation

Sleep Study is recommended if the following:

1. If BMI is greater than 40
2. If any box is checked in Sections A-B, sleep study is recommended
3. If any two boxes in Section C are checked
4. If Section D has two positive categories (shaded/highlighted answers)