ST. JOSEPH'S
UNITY HEALTH TORONTO

SLEEP MEDICINE CLINIC
OUTPATIENT CONSULTATION REFERRAL

Medical Diagnostics Department
30 The Queensway, Toronto, ON. M6R 1B5
1st Floor East Wing

Telephone: 416-530-6325
Fax: 416-530-6702

Patient Demographics

Name: _____
☐ Male ☐ Female
MRN: _____
DOB: _____
Address: _____
_____
Telephone: _____
OHIP #: _____

INCOMPLETE FORMS WILL BE RETURNED AND NOT PROCESSED

Urgency of Consultation Requested: ☐ Urgent (within 72 hours) ☐ Routine

REFERRAL REQUEST

☐ Consultation only
☐ Consultation and sleep study – *Testing to be offered at an external facility where the Respirologists have privileges. Site to be selected in discussion with the patient*

REASON FOR REFERRAL

☐ Obstructive Sleep apnea/snoring
☐ Excessive daytime sleepiness
☐ Restless legs
☐ Insomnia
☐ Other/Co-morbidities:

OTHER INFORMATION

Is the patient on CPAP/BiPAP? ☐ Yes ____cmH2O
Is the patient on oxygen? ☐ Yes ____L/min
Is the patient's weight >300lbs/136kg? ☐ Yes
Other special needs?

ADDITIONAL PATIENT INFORMATION

Does the patient consent to appointment information being disclosed in a telephone message?
Is the patient able to come on short notice?

Patient e-mail address:_____ Send MyChart invite? ☐ Yes (e-mail) ☐ Yes (SMS) ☐ No
Interpreter required? ☐ Yes Language: _____

REQUESTING PHYSICIAN

Address: _____
Postal Code: _____ Telephone: _____
Fax: _____ CPSO #: _____
Copy to: _____ *MD (Physician's Printed Name)*

DATE DD/ Month/YYYY	**SIGNATURE**	**PRINT NAME**