



**SLEEP MEDICINE CLINIC**  
**OUTPATIENT CONSULTATION REFERRAL**

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

Telephone: 416-530-6328  
Fax: 416-530-6702

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 Respiriologists have privileges. Site to be selected in discussion with the patient*

**REASON FOR REFERRAL**

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

**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?  Yes  No  
Is the patient able to come on short notice?  Yes  No

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
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