Kingston General Hospital

SLEEP REFERRAL

Mailing Address: Room 20-303, Richardson House
Queen's University, 102 Stuart Street
Kingston, Ontario K7L 2V6

Telephone: 613-548-2382
Fax #: 613-549-1459
www.kgh.on.ca

Download this form:
http://www.kgh.on.ca/healthcare-providers

PATIENT INFORMATION

Name _____

DOB (yyyy/mm/dd) _____

OHIP # _____ CR# _____

Telephone _____

Address _____

_____

*Occupation _____

*** Required Information for prioritization**

Has the patient ever had a sleep study in Ontario? ☐ Yes ☐ No

Referral Request:

☐ Sleep Study only - the result will be sent to referring physician.

☐ Sleep study to confirm sleep apnea, followed by initiation of treatment (if sleep apnea confirmed) through KGH Sleep Disorders Education Centre. Follow-up by referring physician.

☐ Sleep physician consultation and sleep studies as deemed necessary by sleep specialist.

*** Reason for Referral:**

☐ Unrefreshing Sleep	☐ Restless Legs	☐ Suspected Narcolepsy	☐ Insomnia
☐ Snoring	☐ Periodic Limb Movements	☐ Abnormal Sleep Behaviours	☐ Night Sweats
☐ Excessive Daytime Sleepiness	☐ Sleepiness when driving	☐ Congestive Heart Failure	☐ Obesity
☐ Witnessed Apnea	☐ Hypertension	☐ Overnight Desaturations	☐ Pre-Bariatric Surgery

☐ Other: (specify) _____

Height: _____ m Weight: _____ kg BMI: _____ kg/m^2

Special Care Needs:

Does this patient require? ☐ Oxygen ☐ Night - time meds (e.g. Insulin)

Other _____

All other illnesses: _____

_____

Medications (list): _____

REFERRING PHYSICIAN INFORMATION

Printed Name _____

Telephone _____ Fax _____

Referring Physician's Signature _____ Date (yyyy/mm/dd) _____

Please inform patients that for the sleep study:

1 They **MUST** bring all medications needed to the study.
2 Special care needs must be arranged in advance, by calling 613 548-2382.

FAX TO SLEEP DISORDERS CLINIC Fax 613 549-1459

CLINIC USE ONLY Priority # _____

Prioritized by _____ MD

Print Name _____

Date (yyyy/mm/dd) _____ Time (hhmm) _____

Sleep Physician _____

Clinic Date (yyyy/mm/dd) _____ Time (hhmm) _____

Lab Date (yyyy/mm/dd) _____ Time (hhmm) _____