DSC Referral Form

Urgent ___ Routine ____

Diagnostic Sleep Clinic Tel: 705-472-1967 Fax: 705-472-0689
104 – 60 Champlain St. North Bay Ontario P1B 7M4

Dr. E. Feige MD FCFP Sleep Medicine/Diplomate American Board of Sleep Medicine Medical Director
Focused Practice in Sleep Medicine

Patient's Name _____Sex ___ Birthdate D ____ M ____ Y _____

Health Card # _____ ____ Patient Address _____

Patient e-mail address: _____ Phone # _____

Referring MD _____ Tel _____ Fax _____

MD Address _____Billing #_____

Send copy to _____

Reason for Referral

snoring ____ daytime fatigue ____ napping ____ non-refreshing sleep ____ witnessed apnea ____ AM headache ____ other ___

kicking or moving at night ____ fragmented sleep ____ choking at night ____ abnormal overnight oximetry ____

cardiac risk factors – CHF ____ angina ____ MI ____ bypass surgery ____ **other risk factors** _____

seen at DSC previously ____ seen elsewhere (if so please send sleep reports) ____ When _____ Where _____

Patients will be triaged according to cardiac risks and overnight oximetry if available

Are you suspicious of: SLEEP APNEA ____ RESTLESS LEGS SYNDROME ____

NARCOLEPSY ____ EXCESS DAYTIME SLEEPINESS ____ INSOMNIA ____ PARASOMNIA ____

Would you like: Consultation only _____

Repeat Consult re: lack of improvement _____

Consultation and Polysomnogram (for treatment if indicated) _____

Polysomnogram only _____ CPAP titration _____ BiPAP titration _____

Other _____

Patient Special Needs _____

Or Accommodations Needed _____

Medications: _____

_____

_____

_____ _____

Physician's Signature Date

Date Received:	Instructions:
Triaged Priority 1 2 3	Reviewed by: _____