



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/m²

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) _____