RÉSEAU DE SANTÉ Horizon HEALTH NETWORK

ATLANTIC SLEEP CENTRE
CENTRE DU SOMMEIL DE L'ATLANTIQUE

Atlantic Sleep Centre Referral Form

TO BE COMPLETED IN FULL
[MAIL OR FAX (506 648 6171)]

❑ CATEGORY A
URGENT

1. Public safety issue; i.e., pilot, air traffic controller, truck driver.

State: _____

2. (Relevant) medical illness; i.e., unstable angina

State: _____

3. (Relevant) psychiatric illness; i.e., rapid cycling bipolar

State: _____

❑ CATEGORY B
SEMI-URGENT

Severe daytime symptoms; i.e., unable to stay awake in sedentary situations

❑ CATEGORY C
REGULAR

All other referrals

Previous sleep study or consult? ❑ Yes ❑ No

With whom? _____ Where? _____

When? _____ Diagnosis _____

Date of Referral _____/_____/_____
Month/dd/yyyy

Patient Email Address _____

Name _____ **Date of Birth** _____/_____/_____ **Sex** ❑ Male ❑ Female
Month/dd/yyyy

Medicare _____ **Address** _____

Day Phone _____ **Evening Phone** _____

Provisional Diagnosis: _____

Sleep-Related Symptoms (Night) _____

_____

_____

Sleep-Related Symptoms (Day) _____

_____

_____

Relevant Med/Psych History _____

_____

Relevant Physical Findings _____

_____

Medications _____

_____

Referring Practitioner _____ Signature _____

❑ **Non-Insured: Horizon Staff** ❑ **Non-Insured: Private Practice**

Address _____

Phone _____ FAX _____

Family Practitioner (If Not Referring) _____

Language of Preference for Patient Questionnaire

❑ English

❑ French