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

34485 (05/24)