Sunnybrook
HEALTH SCIENCES CENTRE

U of T NEUROLOGY

Clinical Neurophysiology Unit • Sleep Laboratory
Phone: 416-480-4475 • Fax: 416-480-4674

SLEEP CONSULTATION REQUEST

PATIENT INFORMATION

Name			Date of Birth (yyyy/mm/dd)	
Health Number	Version	MRN		Account
Street Address			Prov.	Suite/Apt.
City/Town			Postal Code	
Home Telephone	Business Telephone		Cellular Telephone	

REASON FOR REFERRAL – ***please check applicable items to assess:***

☐ Snoring/Sleep Apnea ☐ Restless Legs/PLMS ☐ Narcolepsy
☐ Fragmented Sleep ☐ Fatigue/Sleepiness ☐ Refractory Insomnia
☐ Seizures ☐ Parasomnias (unusual sleep behaviors)

MEDICAL HISTORY:

☐ Cardiac arrhythmias ☐ Heart Disease ☐ Pulmonary Disease
☐ Diabetes ☐ Seizures ☐ Parkinson's Disease
☐ Stroke ☐ Head injury ☐ Other (specify below)

_____
_____
_____
_____
_____
_____
_____

REFERRING PHYSICIAN

NAME: _____ BILLING NUMBER: _____

ADDRESS: _____

PHONE: _____ FAX: _____

_____ _____
SIGNATURE OF PHYSICIAN DATE OF REQUEST

Rev. 20140408