



MISERICORDIA
Health Centre
The future of care

SLEEP DISORDER CENTRE REFERRAL

Misericordia Health Centre
99 Cornish Avenue Winnipeg, MB R3C 1A2
Fax back to: 204 779-8657 Telephone: 204 788-8570

Referring Doctor Information:

| | |
|------------|--|
| Name | |
| Address | |
| Fax | |
| Phone | |
| Provider # | |

| | | | |
|---|-----------------------------|---------------------|----------------------------|
| Patient Name: | | | |
| Given Name | Surname | | |
| Home Address/Postal Code: | | PHIN: | |
| | | MHSC: | |
| Date of Birth: | Main Phone #: | Weight (kg): | RCMP # |
| Day Month Year | | | |
| Sex: <input type="checkbox"/> F <input type="checkbox"/> M | Alternative Phone #: | Height (m): | Canadian Military # |
| | | | |
| In-Patient location: | Neck Circ.: cm | BMI: | Treaty # |
| | | | |

| Referral Cause | | Comorbids | |
|--|--|--|--|
| Major Concern (check one) | Secondary/Other Concerns | | |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Snoring | Hypertension (HTN) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Apnea | <input type="checkbox"/> Apnea | Ischemic Heart Disease (IHD) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Insomnia | Congestive Heart Failure (CHF) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Parasomnia | <input type="checkbox"/> Parasomnia | Arrhythmia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Restless Leg Syndrome | <input type="checkbox"/> Restless Leg Syndrome | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Hypersomnolence | <input type="checkbox"/> Hypersomnolence | Chronic Obstructive Pulmonary Disease (COPD) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Respiratory Failure | <input type="checkbox"/> Respiratory Failure | Chronic Respiratory Failure (CRF) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Narcolepsy | <input type="checkbox"/> Narcolepsy | If CRF please submit (if available): | |
| Previous Sleep Study Performed <input type="checkbox"/> Yes* <input type="checkbox"/> No | | <input type="checkbox"/> Spirometry | |
| | | <input type="checkbox"/> ABG | |
| | | <input type="checkbox"/> Overnight Oximetry | |

*Please send copy of previous study
Other relevant medical concerns:

Degree of Daytime Sleepiness - Check all that apply

Severe impairment of quality of life
 Threat to patient's safety
 Falling asleep in high stimulus situations

Some impairment of quality of life
 Falling asleep unintentionally in low stimulus situations

Minimal impairment of quality of life
 Falling asleep sometimes in low stimulus situation

Does patient operate heavy/dangerous equipment/transport vehicles? Yes No
 Would any physical assistance or family support be needed for an overnight study? Yes No
 Details if Yes:

Doctor's Signature

Today's Date

Sleep Lab Chart Copy

Priority Status for appt scheduling completed by Sleep Disorder Centre Personnel only: High Moderate Mild