



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