Office Phone 902-405-3557
Office Fax 902-701-0447
Email infohalifax@avantsleep.com
Website www.avantsleep.com

SLEEP DISORDER REFERRAL FORM
Please fax this referral to: 902-701-0447

LOCATION

☐ **AvantSleep Dartmouth** 250 Baker Drive, Suite 114, Dartmouth, NS B2W 6L4 Canada
☐ **AvantSleep Bedford** 1658 Bedford Highway, Suite 2005, Bedford, NS B4A 2X9 Canada

TEST REQUESTED

☐ Level 3 Sleep Study (to include APAP Treatment and/or Sleep Medicine Consultation if indicated)*
☐ Auto PAP Reassessment

PATIENT INFORMATION

Name ______________________
Health Care Number ______________________
Province ______________________
Birth Date ______________________

Gender ☐ M ☐ F
Height ________ Weight ________ Neck Size ________
Primary Contact Number ______________________
Secondary Contact Number ______________________
Email ______________________

SYMPTOMS

☐ Snoring
☐ Insomnia
☐ Witnessed Apneas
☐ Excessive Daytime Fatigue
☐ Excessive Daytime Sleepiness
☐ Restless Legs Syndrome
☐ Other ________________

MEDICAL CONDITIONS

☐ MI/CAD
☐ Seizures/Epilepsy
☐ GERD
☐ Fibromyalgia
☐ Mood Disorder
☐ Anxiety Disorder
☐ Hypertension
☐ Diabetes
☐ Stroke
☐ Asthma/COPD
☐ Chronic Pain
☐ CHF
☐ Cardiac Arrhythmia
☐ Other ________________

COMMENTS / MEDICATIONS

____
____
____

REFERRING PHYSICIAN

Physician ______________________
PRACID # ______________________
Street Address ______________________
City ______________________

Phone ______________________
Fax ______________________
Email ______________________
Postal Code ______________________

Signature ______________________
Date ______________________

☐ *PLEASE CHECK IF YOU WOULD LIKE US TO SEND YOU MORE REFERRAL FORMS.*

** LEVEL 3 STUDY INTERPRETATION AND SLEEP MEDICINE CONSULTATION PROVIDED BY MEDSLEEP PHYSICIANS*

v11 • 27 Aug 2015