

Patient Name :

Address :

Postal Code:

Phone # Home :

Work # :

Age/ DOB :

Sex : f m

Health # /version code :

▶ This form is NOT needed if you send a signed letter

▶ **What questions do you want answered?**

1.

2.

▶ **The patient's main symptoms are:**

- Snoring / Sleep Apnea** awakes choking apneas noted by others
 prior diagnosis of sleep apnea at NNSDC on cpap
 prior diagnosis of sleep apnea at _____: we need their reports on cpap
- Needs New CPAP Equipment** stable without symptoms – just needs new gear
 needs more extensive review because:
- Drowsiness** mild moderate severe critical because:
- Restless Limb Syndrome**
- Insomnia** can't get to sleep can't get back to sleep both early a.m. wakening
 fibromyalgia/ chronic fatigue syndrome (append letter with details)
 with psychological problems (append psychiatry consults or a letter with details)
- Abnormal Sleep Timing** trouble coping with shift work delayed sleep timing
- Abnormal Sleep Behaviours** sleep walking sleep related violence
 other, please describe:
- Suspected Narcolepsy**
- Other**...please describe:

▶ **Always append cumulative summary / problem list**▶ **Include all previous psychiatry notes / other important consults**▶ **Phone for urgent cases**_____
Print Your Name_____
Physician #_____
MD's Signature required_____
Fax #_____
Your Phone #physicians & patients can get information/ links to resources/ virtual tour/ referral forms: www.northernnightssleep.ca