KINGSTON GENERAL HOSPITAL

SLEEP REFERRAL

Mailing Address: Room 20-303, Richardson House
Queen's University, 102 Stuart Street
Kingston, Ontario K7L 2V6

Telephone: 613-548-2382
Fax #: 613-549-1459
www.kgh.on.ca

Download this form: http://www.kgh.on.ca/programs/sleep.asp

PATIENT INFORMATION

Name _____

DOB (YYYY/MM/DD) _____

OHIP # _____

CR# _____

Telephone _____

Address _____

_____

_____

*Occupation _____

*** Required Information for prioritization**

*** Reason for Referral: Has the patient ever had a sleep study in Ontario? Yes/No**

- ☐ Unrefreshing Sleep
- ☐ Restless Legs
- ☐ Suspected Narcolepsy
- ☐ Insomnia
- ☐ Snoring
- ☐ Periodic Limb Movements
- ☐ Abnormal Sleep Behaviours
- ☐ Night Sweats
- ☐ Excessive Daytime Sleepiness
- ☐ Sleepiness when driving
- ☐ Congestive Heart Failure
- ☐ Witnessed Apnea
- ☐ Hypertension
- ☐ Overnight Desaturations
- ☐ Other: (specify) _____

Height: _____ m Weight: _____ kg BMI: _____ kg/m^2

Special Care Needs:

Does this patient require? ☐ Oxygen ☐ Night - time meds (e.g. Insulin)

Other _____

All other illnesses: _____

Medications (list): _____

REFERRING PHYSICIAN INFORMATION

Printed Name _____

Telephone _____ Fax _____

Referring Physician's Signature _____ Date (YYYY/MM/DD) _____

Please inform patients that for the sleep study:

1 They **MUST** bring all medications needed to the study.
2 Special care needs and disabled parking must be arranged in advance, by calling 613 548-2382.

FAX TO SLEEP DISORDERS CLINIC Fax 613 549-1459

CLINIC USE ONLY Priority # _____

Prioritized by _____ MD

Print Name _____

Date (YYYYMMDD) _____ Time (hh mm) _____

Sleep Physician _____

Clinic Date (YYYY/MM/DD) _____ Time (hh mm) _____

Lab Date (YYYY/MM/DD) _____ Time (hh mm) _____