



Winnipeg Regional Health Authority  
Office régional de la santé de Winnipeg  
Caring for Health À l'écoute de notre santé

**SLEEP DISORDER CENTRE REFERRAL**  
810 Sherbrook Street  
Room RS 309  
Winnipeg, MB R3A 1R9  
Fax back to: (204) 787-1220  
Telephone: (204) 787-2063



BRANDON REGIONAL HEALTH AUTHORITY

**SLEEP DISORDER CENTRE REFERRAL**  
150 McTavish Avenue East  
Brandon, Manitoba, R7A 2B3  
Fax back to: (204) 578-4985  
Telephone: (204) 578-4085

**Referring Doctor Information:**

Name	
Address	
Fax	
Phone	
Provider #	

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

**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	
*Please send copy of previous study		<input type="checkbox"/> ABG	
Other relevant medical concerns:		<input type="checkbox"/> Overnight Oximetry	

**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 Disorders Centre Personnel only:    High    Moderate    Mild