

Kelowna Sleep Clinic

Dr. Ronald Cridland Inc

Patient Referral Requisition

Patient Name: _____ Home Phone: _____
Address: _____ Work Phone: _____

Other Contact: _____
DOB: d/m/yr _____ PHN#: _____

Referring Physician: _____ Phone: _____
Address: _____

Billing #: _____

Type of referral:

- Sleep Disorders Consultation with Polysomnogram as indicated
- Level III Cardiorespiratory Study – **sleep apnea screening only** with no consultation

Reason for referral:

- | | | |
|---|--|---|
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Restless Legs Syndrome | <input type="checkbox"/> Chronic Fatigue/Fibromyalgia |
| <input type="checkbox"/> Excessive Daytime Sleepiness | <input type="checkbox"/> Periodic Limb Movements | <input type="checkbox"/> Seasonal Affective Disorder |
| <input type="checkbox"/> Narcolepsy | <input type="checkbox"/> Parasomnia (eg: sleepwalking) | <input type="checkbox"/> Other (please specify) |
| <input type="checkbox"/> Chronic Insomnia | <input type="checkbox"/> Shift-work related problem | _____ |

Relevant History: _____

Current Medications: _____

Is this referral for disability or medico-legal purposes? Yes No

If this referral is URGENT, please explain: _____

Additional Comments or concerns: _____

- Please fax to: **(250) 862-3052**, or mail to: **#205 - 2040 Springfield Rd, Kelowna, BC V1Y 9N7**.
- For referral purposes, Dr. Cridland's MSP billing # is: 26582.

PLEASE ENCLOSE copy of CBC, TSH, Oximetry or Sleep Study reports if available to prevent duplication.

We will contact the patient directly to book the appointment. Thank you for your referral.

Physician Signature: _____ Date: _____