Vancouver Coastal Health
Promoting wellness. Ensuring care.

UBC Hospital Sleep Disorders Program Referral Form

G285 - 2211 Wesbrook Mall, Vancouver V6T 2B5
Phone: 604-822-7606; Fax: 604-822-9744

Please ensure patient contact information is current DATE: _____

Name _____ Male Female
Last name *First Name* *Initial*

D.O.B. ____/____/____ PHN: _____
Day Month Year

Address: _____
Street Address *City* *Postal Code*

Phone Number (DAY):_____ Phone Number (NIGHT): _____

Referring Doctor: _____ Specialty: _____

Billing Number: _____ Phone: _____ Fax: _____

Primary Care Physician (if different):_____

Please indicate suspected sleep disorders (tick all that apply):

❑ Sleep Apnea ❑ Insomnia ❑ Other_____

❑ Parasomnia ❑ Narcolepsy

Please indicate with a check mark if your patient has had:

❑ Previous assessment at this clinic ❑ Previous sleep study

❑ Overnight oximetry ❑ Current/prior use of PAP device (CPAP/BiPAP)

- **PLEASE ATTACH: Copies of relevant test results or consultations**
  Details of any previous treatment
  A list of the patient's current medications

Main reason for this referral: _____

_____

Epworth Sleepiness Score_____ (can be downloaded from http://epworthsleepinessscale.com)

Does the patient have a co-morbid disease/pregnancy? Circle all that apply: Ischemic heart disease, cerebrovascular disease, congestive heart failure, refractory systemic hypertension, obstructive/restrictive lung disease, pulmonary hypertension or hypercapnic respiratory failure, or pregnancy.

Does the patient have a safety critical occupation? Yes No

- Individuals working with machinery, or employed in hazardous occupations
- Truck, taxi or bus drivers, railway engineers, airline pilots, air traffic controllers, aircraft mechanics, ship captains and pilots. Car drivers who admit to having fallen asleep while driving within the past two years.

REFERRALS FAXED TO 604 822-9744 WILL BE TRIAGED BY A SLEEP DISORDER PHYSICIAN
INCOMPLETE REFERRALS WILL BE RETURNED FOR COMPLETION