Children's Hospital
London Health Sciences Centre

SLEEP LABORATORY REFERRAL FORM
800 Commissioners Rd E, London, ON N6A 5W9
Tel: 519-685-8500 **Fax: 519-667-6856**

- ***The focus of the sleep laboratory at present is the evaluation of complex respiratory and neurological problems. Sleep study has limited value in the evaluation of behavioural disorders, such as insomnia. At present we are not evaluating otherwise healthy children with sleep related behavioural disorders.***
- ***Please provide complete information to avoid delays and to assist in prioritizing patients***

DATE OF REFERRAL:_____

PATIENT IDENTIFICATION:
Name:_____ HCN: _____
DOB (yyyy/mm/dd):_____ Sex: _____ Interpreter required: ☐ No ☐ Yes, Language spoken:_____
Address: _____
Parent/guardian name: _____ Home #: _____
Alternate #: _____

REQUESTED SERVICE: Pease note, patients will be triaged to lab or clinic on the basis of the information provided.
☐ Consultation and sleep study as required ☐ Sleep study only
☐ Urgent (please explain):_____

REASON FOR REFERRAL (please include medical diagnoses/medical history):
_____
_____

CHECK ALL THAT APPLY:

NOCTURNAL SYMPTOMS:		DAYTIME SYMPTOMS/SIGNS:		DIAGNOSES:	
☐ Snoring/Noisy resp	☐ Cyanosis	☐ Excessive sleepiness	☐ Fatigue	☐ Craniofacial abn	☐ Obesity
☐ Pauses/Apnea	☐ Gasping	☐ Irritability	☐ Hyperactivity	☐ Seizure/Epilepsy	☐ ADHD
☐ Mouth breathing	☐ Choking	☐ Poor concentration	☐ Anxiety	☐ Cerebral palsy	☐ Arrythmia
☐ Morning headache	☐ Seizure	☐ Poor school performance		☐ Congenital Heart Dz	☐ BPD
☐ Limb Movements	☐ Awakenings	☐ Enlarged tonsils / adenoids		☐ Neuromuscular Dz	☐ Asthma
☐ Restless sleep	☐ Enuresis	☐ Family Hx of sleep disordered breathing		☐ Prader-Willi	☐ Trisomy-21
Other: _____		Other:_____		Other:_____	

PAST MEDICAL HISTORY:

Medications: _____
BMI: _____ Allergies: _____
Tonsils removed: ☐ No ☐ Yes, when:_____ Adenoids removed: ☐ No ☐ Yes, when:_____
ENT following: ☐ No ☐ Yes, who:_____ Other physicians involved in care: _____
Previous sleep study: ☐ No ☐ Yes, when:_____ . If yes: ☐ LHSC ☐ Elsewhere (please include a copy of the report)
Is the patient on oxygen: ☐ No ☐ Yes, How much_____ What method_____
Does the patient sleep with respiratory technology: ☐ None OR Yes - ☐ CPAP ☐ BiPAP ☐ Invasive-Ventilation
If yes: Mode:_____ Settings (IPAP, EPAP, Rate):_____ Interface:_____

REFERRING MD:_____ **SIGNATURE:**_____
BILLING NUMBER:_____ **FAX:**_____ **ADDRESS:**_____