Alberta Health Services

Sleep Centre Referral
(Foothills Medical Centre)

For questions or more information:
Phone **403.944.2404**
Fax **403.270.2718**
or visit http://www.albertahealthservices.ca/sleepcentre.asp

Patient Name	
Address	
City/Province	Postal Code
Home Phone	Gender ☐ Male ☐ Female
PHN#	DOB *(yyyy-Mon-dd)*

Referral information must be complete before processing occurs *(see reverse).*
Referrals are accepted from all physicians. Referrals will not be processed unless appropriate recent results are attached. (*We will contact your patient for an appointment.)*

Date of Referral *(yyyy-Mon-dd)*	MD PRAC ID	
Referring Physician	Phone	Fax
Family Physician	Phone	Fax

Condition of Primary Concern

☐ Obstructive Sleep Apnea

☐ Insomnia

☐ Restless Legs and/or Periodic Limb Movements

☐ Parasomnias (Sleep Walking, Abnormal Movements)

☐ Narcolepsy

Additional History

☐ Severe daytime Somnolence
- ☐ Patient falls asleep and is at risk at work
  - Profession _____
  - Describe Work _____
- ☐ Patient falls asleep while driving
  - How often? _____
  - Accidents: ☐ Yes ☐ No When?
- ☐ Patient is a professional driver

☐ Chronic sleep deprivation

☐ Patient is going for major surgery within the next 6 months
- Reason _____

☐ Prior Sleep/Pulmonary Function test *(please include)*

Blood Pressure	Weight	Height	Neck Circumference

History *(Check all that apply, if condition is unstable note in comments section)* ***Required documents to be sent - See Reverse***

☐ Congestive Heart Failure *
☐ Ischemic Heart disease *(myocardial infarction, angina)* *
☐ Cardiac Arrythmias *
☐ Respiratory failure * *(PO2 less than 50; PCO2 greater than 50)*
☐ Stroke
☐ Other Respiratory Disease *(specify)*_____
☐ Neuromuscular Disease
☐ Other Neurologic Disease *(specify)*_____
☐ Depression

Comments *(provide reasons below if patient should be considered for urgent status)*

_____

_____

Medications	Dose	Frequency

Office Use Only

Physician Name	Signature	Date *(yyyy-Mon-dd)*

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Required Documents Sent (√)

☐ Congestive Heart Failure, Ischemic Heart Disease, and/or Cardiac Arrhythmias

- Complete medical and surgical history
- Reports of recent investigations (CXR; Echo, MUGA, Angio, PFT's, blood work)
- Relevant consultation notes

☐ Respiratory Failure

- Complete medical history including the probable aetiology
- Reports of recent investigations (CXR, PFT's, ABG's, Echo, blood work)
- Current treatment - oxygen, CPAP, BIPAP, medications
- Relevant consultation notes

General Information

Thank you for referring your patient to the Foothills Medical Centre Sleep Centre. Our Centre receives over 1,600 patient referrals annually; 70% have sleep apnea, most with excessive daytime sleepiness. Our Centre offers:

- Diagnostic sleep studies (ambulatory monitoring and polysomnography);
- Counselling;
- Education;
- Research;
- Multidisciplinary teams; and
- Partnerships

Booking Criteria

Unfortunately, at this time, we have a lengthy waiting list for non-urgent referrals. We will book an appointment with your patient as soon as possible.

Please ensure that the Referral form is complete – our triage procedure is only possible if we have accurate information about your patient. The information will allow us to direct the patient to the correct care provider and designate appropriate priority.

- Referrals are accepted from all physicians
- Referrals can be faxed or sent by mail/transmed, but not both. Your referral will be triaged by our Sleep Specialist and your patient added to our waiting list. We will send your patient a letter confirming that we have received the referral. Please inform your patient that they will likely have a lengthy wait
- If you believe your patient requires urgent assessment, please provide details. We will try to accommodate this request
- **We will call your patient to book the appointment**
- If you are aware of any patient changes (e.g. Phone number, address etc.) please notify us

Thank you for your cooperation.