



**SLEEP DISORDER CENTRE REFERRAL**  
 MHC 370-99 Cornish Avenue  
 Winnipeg, MB R3C 1A2  
 Fax back to: (204) 779-8657  
 Telephone: (204) 788-8570



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> Day _____ Month _____ Year _____	<b>Main Phone #:</b> _____	<b>Weight (kg):</b> _____	<b>RCMP #</b> _____
<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	
		<input type="checkbox"/> ABG	
		<input type="checkbox"/> Overnight Oximetry	

Other relevant medical concerns: \_\_\_\_\_

**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 Disorder Centre Personnel only:  High  Moderate  Mild