DR KP
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PATIENT REFERRAL FORM

ONCE THE REFERRAL FORM IS SUBMITTED, PATIENTS WILL BE CONTACTED DIRECTLY FOR APPOINTMENTS.

Surname:		Given Name(s):	
Date of Birth:		Email:	
Gender:		Personal Health Number:	
Address:			
	City	*Province*	*Postal Code*
Home Phone:		Work Phone:	Cell Phone:

Referred By:		MD PracID:	
Clinic Name:		Email:	
Address:			
	City	*Province*	*Postal Code*
Phone:		Fax:	Family Physician: *(if different from Referring Physician)*

Mandatory - Check all that apply:

Primary Sleep Concerns:

- ☐ Obstructive Sleep Apnea (Snoring)
  - ↳ ☐ CPAP Adherent ☐ CPAP Non-Adherent
- ☐ Insomnia (Non-Restorative Sleep)
- ☐ Excessive Daytime Sleepiness
- ☐ Shift Work/Jet Lag/Delayed Sleep Phase
- ☐ Other, please specify:

Movement Disorders:

- ☐ Restless Legs Syndrome
- ☐ Periodic Limb Movement Disorder
- ☐ Sleep Bruxism
- ☐ Other, please specify:

Parasomnia:

- ☐ Sleepwalking/Night Terrors
- ☐ Violent behavior in sleep
- ☐ Nightmares
- ☐ Other, please specify:

Safety Sensitive Occupation:

- ☐ Doctor/Nurse
- ☐ Oilfield Worker
- ☐ Professional Driver
- ☐ Airline Pilot/Flight Staff
- ☐ Railroad Engineer/Conductor
- ☐ Emergency First Responder (EMS/Police/Fire)
- ☐ Other, please specify:

Current Medications / Additional Medical Information:

Copies of these referral forms can also be downloaded from our website at ***www.DRKP.ca/referrals*** *and returned by fax or email.*