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SLEEP CLINIC REFERRAL
Abbotsford Regional Hospital

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Instructions: Please select the sleep specialist that you wish to refer your patient to, then fax requisition.

Abbotsford Area Sleep Specialist:

☐ **Dr. Mehdi Keshmiri** Fax: 604-853-8820 Phone: 604-853-8810	☐ **Dr. Dave Williams** Fax: 604-853-0695 Phone: 604-853-9022	☐ **Dr. Shavinder Gill** Fax: 604-870-3279 Phone: 604-870-3277	☐ **Dr. Darrin Wiebe** Fax: 604-504-1644 Phone: 604-621-0841

Surrey Area Sleep Specialist:

☐ **Dr. Giuseppe Giustino** Fax: 604-582-2199 Phone 604-582-2100	☐ **Dr. E. Lawson** Fax: 778-293-0591 Phone 778-293-0592

PATIENT INFORMATION:

Last name:	First name:
Date of birth (dd/mm/yyyy):	PHN:
Pronouns:	Gender: ☐ Female ☐ Male ☐ Other, specify:
Primary phone number:	Secondary phone number:
Email:	
Address:	

CLINICAL INFORMATION:

☐ Snoring ☐ Apneas ☐ Insomnia ☐ Daytime sleepiness ☐ Restless legs
☐ Nocturnal seizures ☐ Shift worker ☐ Fatigue ☐ Sleep talking/walking ☐ Oral appliance
☐ On supplemental O_2 ____ lpm ☐ CPAP/BiPAP _____cm H_2O
☐ Others _____

COMORIBIDITIES:

☐ MI/CAD ☐ TIA/CVA ☐ CHF ☐ Hyperlipidemia
☐ Hypertension ☐ Obesity ☐ Depression ☐ Anxiety
☐ Substance Abuse ☐ Neuromuscular Disease ☐ Diabetes ☐ Other: _____

CONSULTATION REQUEST:

☐ Routine ☐ Re-assessment

URGENT:
☐ Safety Critical Occupation ☐ Motor Vehicle Accident
☐ Severe daytime sleepiness ☐ Driver's License Suspension
☐ Severe sleep apnea on oximetry / Level 3 test ☐ Recent MI or CVA
☐ Pre-Operative Assessment

Additional information:

Please include any available and relevant information for review

Family physician:	MSP number:
Referring practitioner:	MSP number:
Signature:	Date: