Seymour
SLEEP MEDICINE

Phone: 604-416-1821 Fax: 236-521-3634
1290 Hornby Street, 3rd Floor, Vancouver, BC V6Z 0A3

Dr. Rob Comey (Psychiatry) **Dr. Richard Feige (Respirology)**

SLEEP DISORDER REFERRAL FORM

Please fax this form to: 236-521-3634

Referring Physician's Name ____________________ Address ____

MSP Number ________________________________

PATIENT INFORMATION

Name __________________________ Preferred Phone _______________________

PHN ___________________________ Other Phone __________________________

Date of Birth _____________________ Address _____________________________

☐ Male ☐ Female ☐ Transgender ☐ Non-binary City ______________ Postal Code ________

Email ___________________________

HISTORY OF SLEEP PROBLEMS

☐ Snoring
☐ Apnea
☐ Excessive Sleeping
☐ Fatigue
☐ Narcolepsy
☐ Restless Limbs
☐ Periodic Limb Movement
☐ Parasomnia (e.g. sleepwalking)
☐ Circadian rhythm concern
☐ Insomnia
☐ Other _________________________

Please include any relevant medical or mental health reports such as past sleep studies.

MEDICAL CONDITIONS

☐ CAD
☐ Stroke/TIA
☐ CHF
☐ Hypertension
☐ Diabetes
☐ Arrhythmia
☐ Mood Disorder
☐ Anxiety Disorder
☐ Other Mental Health
☐ Chronic Pain
☐ Fibromyalgia
☐ Other _________________________

MEDICATIONS

____

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Allergies____

PHYSICAL FINDINGS

Height ________________________ Weight ____

Other ____

SPECIAL NEEDS

☐ Translator Needed (language) ____

☐ Other ____

☐ *PLEASE CHECK IF YOU WOULD LIKE US TO SEND YOU MORE REFERRAL*