
Personal Information:

Name: _____

DOB: _____ OHIP#: _____

Contact #: _____

Age: _____ Gender: Male Female Height: _____ Weight: _____

Referring Physician:

Name: _____

Address: _____

Phone: _____

Fax: _____

Billing #: _____

REASON FOR REFERRAL: (please circle all relevant)**COMMON NIGHTTIME SYMPTOMS**

- snoring, breathing problems, sleep apnea
- bed wetting (enuresis)
- teeth grinding (bruxism)
- sleep walking (somnambulism)
- nightmares, night terrors
- RLS/PLMS
- Sweating
- Seizure disorder
- Insomnia

COMMON DAYTIME SYMPTOMS

- difficulty waking up
- excessive sleepiness
- tiredness
- irritability
- hyperactivity
- behavioral problems in school
- declining school performance
- other _____

History & Medical Information: _____

Referring Physician Signature: _____

Date: _____