London Pediatric Sleep Clinic

239 Oxford St. East
London, Ontario

Phone: 519-433-2242
Fax: 519-645-7565

Patient Name: _____ **DOB:** / / (DD/MM/YYYY) M F (Gender)

Address: _____

Tel.#: *Home:* ( ) *Work/cell:* ( )

Email: _____

Date: _____ (DD/MM/YYYY)

Health Card #: _____ **Version Code:** _____

__ **Sleep Study, consultation and management as required**
__ **Consultation, if required sleep study and management**
__ **Sleep Study only (for other sleep medicine trained physician)**

Previous Sleep Study: __ **Yes** __ **No** **if yes, sleep study Date:** _____

ATTENTION TO:
__ Dr. C. Shapiro __ Dr. B. Lyttle

FAMILY PHYSICIAN (if not referring physician)**:**
Dr.
Address:

Tel. #: ( )

REFERRING PHYSICIAN:
Dr.
Physician/Billing # _____
Address:

Tel. #: ( )
Signature: _____

OTHER PHYSICIANS TO RECEIVE RESULTS:
Dr.
Address:

Tel. #: ( )

REASON FOR REFERRAL:

__ Snoring	__ Narcolepsy	__ Treatment Follow-Up	__ Obesity
__ Sleep Apnea	__ Parasomnia	__ Circadian Rhythm Disorder	__ Impotence
__ Insomnia	__ Nocturnal Seizure	__ Mood Disorder	__ Head injury
__ Excessive Daytime Sleepiness	__ CPAP Titration	__ Nocturnal Panic	__ Tourette's
__ Restless Legs Syndrome	__ CPAP Follow-Up	__ Fibromyalgia	__ Parkinson's
__ Periodic Limb Movements	__ Oral Appliance Assessment	__ Rhythmic Movement Disorder	__ Neuromuscular Disease
__ Maxillofacial Assessment	__ ENT Assessment	__ Psychological Sleep Management	

__ OTHER _____

Past Medical History:

Medications: None