The focus of the sleep laboratory at present is the evaluation of complex respiratory and neurological problems. Sleep study has limited value in the evaluation of behavioral disorders, such as insomnia. At present we are not evaluating otherwise healthy children with sleep related behavioral disorders.

In order to help us best prioritize and best serve the needs of your patients, all parts of this form must be completed. PLEASE PRINT.

Date of Referral ____________________________

Referring MD: ____________________________    Signature ____________________________

Reason for Referral (Please print):

☐ Sleep study only    ☐ Sleep study and Respirology Consultation    ☐ Sleep study and Neurology Consultation

☐ Urgent, please explain:

<table>
<thead>
<tr>
<th>Pre-existing medical conditions:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Neuromuscular disease</td>
<td>____________________________</td>
</tr>
<tr>
<td>☐ Genetic syndrome/Craniofacial anomalies</td>
<td></td>
</tr>
<tr>
<td>☐ Oxygen/CPAP/BiPAP dependent</td>
<td>____________________________</td>
</tr>
<tr>
<td>☐ Cardiac disease</td>
<td>____________________________</td>
</tr>
<tr>
<td>☐ Neurological disorder</td>
<td>____________________________</td>
</tr>
<tr>
<td>☐ Obesity</td>
<td>____________________________</td>
</tr>
<tr>
<td>☐ Asthma/Chronic Lung Disease</td>
<td>____________________________</td>
</tr>
<tr>
<td>☐ Other medical problems</td>
<td>____________________________</td>
</tr>
</tbody>
</table>

*Special requirements* (wheelchair accessibility, lift, pumps, In-Exsufflator, diet, other)

In order to assess urgency, we need information about symptoms:

☐ Witnessed respiratory pauses > 10 seconds  ☐ Snoring
☐ Gasping/struggling to breathe at night    ☐ Frequent nocturnal arousals
☐ Morning headaches                          ☐ Daytime hypersomnolence
☐ Declining school performance               ☐ Seizures
☐ Presumed night terrors                     ☐ Symptoms of depression

(Internal Sleep Lab use Only)

Date received: _______________    Referral #: _______________

☐ New Patient

Triage:    ☐ Emergency    (< 2 weeks)    ☐ Denied Reason: ☐ Referral does not meet criteria
            ☐ Urgent    (< 3 months)    ☐ Patient Admitted
            ☐ Semi-Urgent    (< 6 months)    ☐ Patient Request

☐ Return Patient due: _______________

Incomplete ☐ Missing patient demographic information     Referred out to:
Reason:    ☐ Missing Relevant Patient Reports    ☐ ENT Clinic
            ☐ Referring Physician Request    ☐ Outside Pediatrician: ____________________________
            ☐ Unable to Contact Family/ Unable to Reach    ☐ Adult Sleep Lab: ____________________________
            ☐ Other: ____________________________    ☐ Other: ____________________________

Staffing Criteria:    ☐ Complex- Behavioural (Behavioural issues, developmental delay or age 6 months- 3 years)
Referral Type       ☐ Complex Respiratory (i.e. ventilated, tracheostomy, complex respiratory illness)
                      ☐ Complex- 1:1 Respiratory (i.e. ventilated, tracheostomy, complex respiratory illness)
                      ☐ Simple- (not complex behavioural or respiratory)

Schedule With:    ☐ Sleep Study Only    ☐ Sleep Clinic Only (MacLusky, Katz)    ☐ Sleep Study Followed by Clinic (MacLusky, Katz)

TRIAGED BY: ____________________________