



Sleep Screening Referral Form

Referral to: Dr Elaine Ng

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Patient's Information

Full name: _____
DOB: _____
Address: _____
Phone: _____
Email: _____

Reason for referral: _____

Medical History:

Drug Allergies:

Prior sleep study? Y/N (please submit if recent study)

**Please attach any relevant reports, X-rays or records.*

The patient has suspected :

- Sleep disordered breathing disorder
- Hypersomnia
- Parasomnia
- Insomnia
- Circadian Rhythm Disorder
- Sleep Movement Disorder
- Unknown sleep disturbance

I am referring the above patient to Dr Elaine Ng for a full sleep evaluation and screening for all sleep disorders. The patient understands they will undergo non-invasive craniofacial clinical assessment, which includes radiographic analysis and Level 2/3/4 home sleep study.

Referring Clinician: _____ Email: _____

Clinician's Signature: _____ Date: _____

The following patients are contraindicated for ambulatory sleep studies and will require in-lab testing: significant cardiopulmonary disease, dementia (or diminished mental capacity and unable to co-operate), history of stroke in the past 180 days, neuromuscular condition, oxygen therapy, obesity hypoventilation, alcohol abuse or chronic opioid use.