McMaster Children's Hospital

Pediatric Sleep Medicine Referral Request

Please fax completed form to **(905) 521-2654**

Contact booking desk (905) 521-2100 x73861 with any further inquiries

Patient's Last Name	First Name	
Address – Street	City	Postal Code
Telephone: ( )	Ext.	
Cell Phone: ( )		
Date of Birth (yyyy/mm/dd)	Age	Gender ☐ M ☐ F
HIN	Family Physician	

☐ Consult Only ☐ Urgent

☐ Consult and Follow-Up ☐ Non-Urgent

***** **Important – Please read before referring** *****

- If the form is not completed in its entirety, it will be sent back for completion
- We do not have a sleep lab at McMaster site. Patients will be sent to external sleep lab for sleep studies if appropriate.
- For patients *13 years old and over*: Please direct your referral to Dr. R. Gottschalk at the Hamilton Sleep Disorders Clinic on Frid Street at Fax (905) 529-2262. Their clinic would require an e-mail and cell phone number to expedite the booking process. An online questionnaire prior to consult is required. This can be done by visiting **www.sleep-clinic-referral.ca**
- Due to high referral volumes and our expertise in *Respiratory* sleep disorders, we do not see patients solely with sleep quality issues, insomnia, or other behavior-related sleep concerns. These referrals should be re-directed to sleep psychiatry (e.g., Youthdale Child & Adolescent Sleep Center in Toronto, or for adolescents with insomnia >13 years old: Dr. Cara Ooi at DECODE insomnia in Toronto)
- Only referrals from within our catchment (Hamilton Niagara Haldimand Brant LHIN) will be accepted

If Parent / Guardian involved in client's care:

Name ______________________________

Phone ________________ Cell ________________

E-mail *(required)* ______________________________

Referral Date (yyyy/mm/dd) ________________ OHIP Billing Number ________________

Referring Physician (print) ________________ Signature ________________

Address ______________________________ Telephone ________________

E-mail (Optional) ______________________________ Fax ________________

REASON(S) FOR REFERRAL *(Please select all that apply)*

☐ Snoring	☐ Narcolepsy	☐ Post Surgical Follow-up	☐ Other:
☐ Witnessed Apnea	☐ Adenoid/Tonsil Hypertrophy	☐ Parasomnia	________
☐ Morning Headache	☐ Restless limb movements	☐ CPAP Follow-up	________
☐ Non-Restorative Sleep	☐ Hypersomnolence/Fatigue	☐ MSLT/MWT	________
☐ Daytime Sleepiness	☐ Narcolepsy	☐ Obesity	________

Relevant details of Referral. If URGENT, please elaborate on reason for urgency:

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Medications: ______________________________

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Has the patient ever had a sleep study in place? ☐ Yes ☐ No

Primary Language: ________________ **Interpreter Required?** ☐ Yes ☐ No