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Respiratory & Sleep Medicine

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PATIENT REFERRAL INFORMATION

TO: **Dr. IVONE FERREIRA** **Fax:416-944-2525** _____

_____

FROM: _____ **BILLING #** _____

ADDRESS: _____

_____ **PHONE #**

DATE: _____ _____

PATIENT: _____ D.O.B.: _____

TEL: H ( ) _____ TEL: B ( ) _____

Patient's Address: HC #: _____

_____

_____

_____

Reason for Referral:

☐ Respiratory Assessment ☐ Sleep Assessment

Medical History:

☐Insomnia
☐Sleep Apnea
☐Snoring
☐Unrefreshing Sleep
☐Parasomnias

Medications (List):

Had Previous Sleep Test

☐YES
☐NO

Please attach the following: ✓

☐ Prior consultation notes
☐ Prior chest x-rays/ ct reports
☐ Prior Sleep Test/ Pft

Physician's Signature: _____ Date: _____