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. 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
☐ Sleep Apnea
☐ Insomnia
☐ Excessive Daytime Sleepiness
☐ Restless Legs Syndrome
☐ Periodic Limb Movements
☐ Maxillofacial Assessment
☐ Narcolepsy
☐ Parasomnia
☐ Circadian Rhythm Disorder
☐ Mood Disorder

☐ OTHER _____

Past Medical History:

Medications: ☐ None