Dr. Rolf Maijer, Inc.

Sleep, Pain and Fatigue Management

REFERRAL FORM

FAX TO: 1-855-266-0505

PATIENT INFORMATION

Name: _____ DOB: _____ ☐ Male ☐ Female

Address: _____ City: _____ Postal Code: _____

Home phone: _____ Email: _____

Cell phone: _____ Appointment Reminders: ☐ Text ☐ Email ☐ None

SYMPTOMS

☐ Excessive sleepiness ☐ Snoring ☐ Restless legs ☐ _____

☐ Daytime fatigue ☐ Witnessed apneas ☐ Morning headaches ☐ _____

☐ Non-refreshing sleep ☐ Insomnia symptoms ☐ Teeth grinding ☐ _____

MEDICAL HISTORY

☐ Hypertension ☐ Heart disease ☐ Diabetes ☐ GERD

☐ Cardiac arrhythmia _____ ☐ Depression ☐ Chronic pain

☐ Atrial fibrillation ☐ Stroke ☐ Anxiety disorder ☐ _____

SLEEP DISORDER DIAGNOSIS

☐ Obstructive Sleep Apnea ☐ Insomnia ☐ Restless Leg Syndrome ☐ _____

Current AHI: _____ Date of Sleep Study: _____ Results Attached? ☐ Yes ☐ No

MEDICATIONS

_____

SLEEP AIDS

_____

REFERRED FOR

☐ Sleep disordered breathing ☐ Alternative to CPAP ☐ Sleep aid assessment

☐ Chronic pain ☐ Bruxing / headaches Medication(s): _____

☐ Chronic fatigue ☐ Insomnia Supplement(s): _____

Comments: _____

_____

REFERRING CLINICIAN / PRACTICE

Name: _____ Address: _____

PRAC-ID #: _____ City: _____ Postal Code: _____

Office Phone: _____ Email: _____

Office Fax: _____ Follow-Up: ☐ By phone ☐ By fax ☐ By email

Signature: _____ Date: _____

Colwood Dental Group ▪ 318 Goldstream Ave ▪ Victoria, BC V9B 2W3 ▪ P: (250) 800-2552 ▪ E: office@drmaijer.com