Youthdale Child and Adolescent Sleep Centre

SLEEP DISORDER ASSESSMENT

227 Victoria St., Lower Level 2, Toronto, Ontario M5B 1T8
Phone: (416) 703-0505 Fax: (416) 703-0507

Personal Information:

Name: _____

DOB: _____ OHIP#: _____

Contact #: _____

Age: _____ Gender: ☐ Male ☐ Female Height: _____ Weight: _____

☐ Consultation, sleep study and management as required
☐ Sleep study and management as required

Referring Physician:

Name: _____

Address: _____

Phone: _____

Fax: _____

Billing #: _____

REASON FOR REFERRAL: (please circle all relevant)

COMMON NIGHTTIME SYMPTOMS

- snoring, breathing problems, sleep apnea
- bed wetting (enuresis)
- teeth grinding (bruxism)
- sleep walking (somnambulism)
- nightmares, night terrors
- RLS/PLMS
- Sweating
- Seizure disorder
- Insomnia

COMMON DAYTIME SYMPTOMS

- difficulty waking up
- excessive sleepiness
- tiredness
- irritability
- hyperactivity
- behavioral problems in school
- declining school performance
- other _____

History & Medical Information: _____

_____

_____

_____

Referring Physician Signature: _____

Date: _____