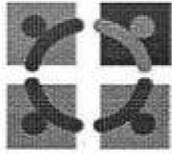

CAMPBELLFORD
MEMORIAL HOSPITAL

Dr. S. Glazer,
Medical Director
Tel(705) 632-0330
Fax(705) 632-0440

Booking Inquiry Line (905) 551-3549

Patient Information

Name of Patient: ____

Date of Birth: (DDMMYYYY) ______________________________________

Health Card Number: ____

Address: ____

Telephone: ____

E-mail: ____

Appointment Type: □ Consult, Diagnostic Sleep Study and CPAP Titration if needed □ Sleep Study Only □ Consult Only

Reason for referral:

____

____

Other medical history:

____

____

Snoring: YES____ NO____ Insomnia: YES____NO____ Hypersomnolence: YES____NO____

Medications:

____

____

Has a sleep study been done previously? YES___ NO___ If yes, when?______________________

Does patient have special needs (ie. O2 user, wheelchair, other disability?) YES____NO____ If yes, please specify: ____

Referring Physician: _______________________ Billing Number: ____________________

Mailing Address: ____

Telephone: ___________________________ Fax: ___________________________

Physician Signature: _______________________ Date: _________________________