CALGARY ZONE **SLEEP CENTRE** REFERRAL QUICK REFERENCE

OUTPATIENT CLINIC

*(Patient does **NOT** need to be seen urgently)*

*Indicate a clear reason for referral and any confirmed diagnosis to assist in directing your referral

- See QuRE Referral Consult Checklists (www.ahs.ca/QuRE) or high-quality referral
- Provide all required information and specific tests/investigations

EXCLUSIONS: FMC Sleep Centre does not supply CPAP/BPAP/Oxygen equipment

REFERRAL PROCESS: If you have Alberta Netcare, submit Alberta Netcare eReferral Consult Requests (www.albertanetcare.ca/eReferral.htm). If you do not have Alberta Netcare, fill out the referral form (www.albertahealthservices.ca/frm-00724.pdf) and fax it to 403-270-2718.

Sleep Medicine – FMC Sleep Centre
Room EG12, Foothills Medical Centre
1403 29 Street NW, Calgary AB T2N 2T9
T: 403-944-2404 | F: 403-270-2718

ASK FOR ADVICE

(Specialists provide advice to physicians for non-urgent questions)

General advice related to sleep disorders:

For physicians in Calgary Zone only:
Call Specialist LINK (www.specialistlink.ca)
Local: 403-910-2551
Toll-free: 1-844-962-5465
Monday to Friday: 8 a.m. to 5 p.m.
(excluding statutory holidays)
Get a call-back within one hour

Refer to **Obstructive Sleep Apnea (OSA) Guidelines** for Diagnosis and Treatment (www.ahs.ca/assets/programs/ps-1771-sleep-osa-guidelines.pdf)

Reason for Referral	Process	Mandatory Info (Essential Investigations)	Extra Info (if available)	Access Target
SLEEP APNEA *Includes:* • Obstructive sleep apnea • Hypoventilation • Central sleep apnea • Persistent apnea despite treatment with CPAP	**Refer to Sleep Centre** **Note:** • Please indicate the condition of primary concern in the reason for sending this referral (e.g. obstructive sleep apnea, hypoventilation, central sleep apnea, or persistent apnea despite treatment with CPAP) • Patient may be asked to undergo home sleep apnea testing (HSAT) and complete a questionnaire from the Sleep Centre • Refer to *Obstructive Sleep Apnea (OSA) Guidelines for Diagnosis and Treatment:* (www.ahs.ca/assets/programs/ps-1771-sleep-osa-guidelines.pdf)	• Indicate any safety concerns (e.g. safety critical occupation, pre-operative consultation)	**Attach if available:** • Sleep study reports • Previous sleep consults • Arterial blood gas result • Pulmonary function test report • Echocardiogram report	30 calendar days

Alberta Health Services

ALBERTA REFERRAL PATHWAYS

CPAP / BPAP / OXYGEN FUNDING (AS REQUIRED BY GOVERNMENT FUNDING AGENCY)	**Refer to Sleep Centre** **Note:** • If the patient is working with respiratory home care company, please provide the company name • The Sleep Centre will request more information directly from the respiratory home care company (e.g. home sleep apnea testing (HSAT) result)	• Indicate the name of the respiratory home care company (Oxygen / CPAP provider) • Indicate any safety concerns (e.g. safety critical occupation, pre-operative consultation)	**Attach if available:** • Sleep study reports • Previous sleep consults • Arterial blood gas result • Pulmonary function test report • Echocardiogram report	60 calendar days
INSOMNIA *Includes:* • Circadian rhythm disorders • Cognitive behavior therapy versus medication consultation	**Refer to Sleep Centre** **Note:** • Patient will be sent a questionnaire from the Sleep Centre • Refer to *Adult Insomnia Guidelines:* (http://www.topalbertadoctors.org/cpgs/?sid=18&cpg_cats=79)	• Indicate comorbid psychiatric condition and stability of symptoms • Indicate any safety concerns (e.g. safety critical occupation)	**Attach if available:** • Previous sleep consults • Details of previous sleep disorders and treatment (CPAP trials or medication)	60 calendar days
EXCESSIVE DAYTIME SLEEPINESS *Includes:* • Narcolepsy • Persistent sleepiness despite CPAP for obstructive sleep apnea	**Refer to Sleep Centre** **Note:** • Please indicate the condition of primary concern in the reason for sending this referral • Patient may be asked to undergo home sleep apnea testing (HSAT) and complete a questionnaire from the Sleep Centre	• Indicate any safety concerns (e.g. safety critical occupation)	**Attach if available:** • Previous sleep consults • Details of previous sleep disorders and treatment (CPAP trials or medication)	60 calendar days
ABNORMAL BEHAVIORS DURING SLEEP *Includes:* • Parasomnias • Restless leg syndrome • Periodic limb movement disorder • Sleep walking • Nightmares	**Refer to Sleep Centre** **Note:** • Please indicate the condition of primary concern in the reason for sending this referral • Patient may be asked to undergo home sleep apnea testing (HSAT) and complete a questionnaire from the Sleep Centre	• Indicate any safety concerns (e.g. safety critical occupation, high risk of injury or dangerous behaviors such as driving, cooking while sleep walking)	**Attach if available:** • Previous sleep consults • Details of previous sleep disorders and treatment (CPAP trials or medication)	60 calendar days

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