

ASK FOR ADVICE *(Specialists provide advice to physicians.)*

General advice related to sleep disorders



eReferral Advice Request *(available in early 2019)* www.albertanetcare.ca/ereferral.htm
 Log into Alberta Netcare and submit your questions with any pertinent documents electronically.
 Get a response within 5 calendar days.

OR

For Physicians in Calgary Zone only:
Call Specialist Link www.specialistlink.ca
 Local: 403.910.2551 | Toll-free: 1.844.962.5456
 Monday to Friday: 8a.m. to 5p.m. (excluding statutory holidays)
 Get a call-back within 1 hour.

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

OUTPATIENT CLINIC

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

- Select referral locations
- See [OuRE Referral Consult Checklists](http://www.ahs.ca/OuRE) (www.ahs.ca/OuRE) for high-quality referral.
- Provide all required information and specific tests/investigations (*see next page*)

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

REFERRAL PROCESS: Submit Netcare eReferral Consult Request (available in early 2019 - www.albertanetcare.ca/ereferral.htm)

SUBSPECIALTY	CLINICS / DIRECTORIES	CONTACT
Sleep Medicine	FMC Sleep Centre Room EG12, Foothills Medical Centre 1403 29 Street NW, Calgary, Alberta T2N 2T9	PH: (403) 944-2404 FX: (403) 270-2718

REASON FOR REFERRAL	PROCESS	MANDATORY INFO (essential investigations & timeframe)	EXTRA INFO (if available)	ACCESS TARGET
SLEEP APNEA <i>includes:</i> Obstructive Sleep Apnea Hypoventilation Central Sleep Apnea Persistent Apnea despite treatment with CPAP	Refer to Sleep Centre. Note: <ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Indicate any safety concerns (e.g. safety critical occupation, pre-operative consultation) 	Attach if available: <ul style="list-style-type: none"> Sleep study reports Previous sleep consults Arterial blood gas result Pulmonary function test report Echocardiogram report 	30 calendar days
CPAP / BPAP / OXYGEN FUNDING (AS REQUIRED BY GOVERNMENT FUNDING AGENCY)	Refer to Sleep Centre Note: <ul style="list-style-type: none"> 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). 	<ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> Sleep study reports Previous sleep consults Arterial blood gas result Pulmonary function test report Echocardiogram report 	60 calendar days
INSOMNIA <i>includes:</i> Circadian Rhythm Disorders Cognitive Behavior Therapy versus Medication Consultation	Refer to Sleep Centre. Note: <ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Indicate comorbid psychiatric condition and stability of symptoms Indicate any safety concerns (e.g. safety critical occupation) 	Attach if available: <ul style="list-style-type: none"> Previous sleep consults Details of previous sleep disorders and treatment (CPAP trials or medication) 	60 calendar days
EXCESSIVE DAYTIME SLEEPINESS <i>includes:</i> Narcolepsy Persistent sleepiness despite CPAP for obstructive sleep apnea	Refer to Sleep Centre. Note: <ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> Indicate any safety concerns (e.g. safety critical occupation) 	Attach if available: <ul style="list-style-type: none"> Previous sleep consults Details of previous sleep disorders and treatment (CPAP trials or medication) 	60 calendar days
ABNORMAL BEHAVIORS DURING SLEEP <i>includes:</i> Parasomnias Restless Leg Syndrome Periodic Limb Movement Disorder Sleep Walking Nightmares	Refer to Sleep Centre. Note: <ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> Previous sleep consults Details of previous sleep disorders and treatment (CPAP trials or medication) 	60 calendar days