



Dr Sameh Samuel

Dr Rajiv Sharma

Dr Adelle Jee

RESPIRATORY AND SLEEP SPECIALISTS

POLYSOMNOGRAPHY REQUEST / REFERRAL FORM

Patient Details

Name: _____ DOB: _____ Phone _____

Area of Concern

Dental

- Chronic Gum Disease from mouth breathing
- Further assesment for Tonsil and Adenoid
- Large Tongue (or scalloped tongue)
- Snoring
- Night Time Teeth Grinding
- Nasal Valve Collapse
- Day Time Teeth Grinding
- Bell Shaped Palate (Narrow & Deep)
- Mouth Breathing/Dry mouth

Medical

- History of Stroke
- BMI
- High Blood Pressure
- Diabetes
- Heart Condition
- Memory/Concentration Issues
- High consumption of caffeine to stay awake
- Day time sleepiness

Other _____

Referring Dentist

Dr _____ Signature _____ Date _____