



# SLEEP WAKE AWARENESS PROGRAM (SWAP)

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**SWAP Organic Farm Program**  
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Caledon, ON, L7C 1V8  
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**Centre for Sleep & Chronobiology College Site**  
295 College St., Suite 301  
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**Centre for Sleep & Chronobiology Wilson Site**  
951 Wilson Ave., Unit 15  
Toronto, ON, M3K 2A7  
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**SWAP Integrative Centre**  
226 Bathurst, Suite 300  
Toronto, ON, M5T 2R9  
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Fax (416) 749-0361

## Patient Referral Information

Patient's Name: \_\_\_\_\_ DOB (dd/mm/yyyy): \_\_\_\_\_

Address: \_\_\_\_\_

Telephone (Home): \_\_\_\_\_ Cell: \_\_\_\_\_

Health Card Number: \_\_\_\_\_ V/C: \_\_\_\_\_

Request for:  Sleep Study & Consultation  Consultation Only

### Reason for Referral

- Sleep Apnea
- Insomnia
- Restless legs
- Non-Restorative Sleep
- Sleepiness, Narcolepsy
- Parasomnias
- Sleep Schedule Disorder
- Nocturnal Seizures

### SWAP Clinics

- Elderly
- Diabetes and Obesity
- Fibromyalgia and Chronic Pain
- RPTSD, Anxiety and Depression
- Students
- Other

Details, if "Other" \_\_\_\_\_

Current Medications: \_\_\_\_\_

Medical History: \_\_\_\_\_

Previous Sleep Studies?  Yes (Provide reports)  No Date of Previous Sleep Study: \_\_\_\_\_

## Referring Physician's Information

Physician's Name: \_\_\_\_\_ Physician's Billing No: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Physician's Telephone: \_\_\_\_\_ Physician's Fax: \_\_\_\_\_

Date (dd/mm/yyyy): \_\_\_\_\_ Physician's Signature: \_\_\_\_\_