

SLEEP STUDY REQUISITION

PLEASE FILL IN ALL INFORMATION AND FAX TO OUR OFFICE. PATIENT WILL BE NOTIFIED DIRECTLY.

1. PATIENT INFORMATION

LAST _____
FIRST _____
D.O.B. _____ MALE FEMALE
HEALTH CARD NO. _____ VC _____
ADDRESS _____
_____ POSTAL CODE _____
PHONE (H) (____) _____ (CELL) (____) _____
E-MAIL _____

2. REQUEST FOR:

- ROUTINE URGENT
- SLEEP STUDY AND CONSULTATION
- SLEEP STUDY ONLY
- CONSULTATION ONLY

IMPORTANT: HAS A SLEEP STUDY BEEN DONE
PREVIOUSLY HERE OR AT ANY OTHER FACILITY?

- NO YES IF YES, PLEASE SPECIFY THE

LAST STUDY DATE: _____

LOCATION: _____

CLINICAL INFORMATION

3. REASON FOR REFERRAL

- SNORING INSOMNIA
- SUSPECTED OSA RESTLESS LEGS
- EXCESSIVE DAYTIME SLEEPINESS
- NARCOLEPSY (REQUIRES DAYTIME TEST)
- ABNORMAL SLEEP BEHAVIOUR (SLEEP WALKING/TALKING)
- OTHER: _____

4. RELEVANT MEDICAL HISTORY:

IS PATIENT ON CPAP?

- NO YES: _____ cmH₂O

IS PATIENT ON OXYGEN?

- NO YES: _____ L/M

- AT NIGHT ONLY DAY AND NIGHT

OTHER: _____

5. REFERRING PHYSICIAN INFORMATION:

NAME _____
OHIP BILLING NO. _____
ADDRESS _____
PHONE (____) _____ FAX (____) _____
COPY TO _____
SIGNATURE _____ DATE _____

6. ADDITIONAL COMMENTS AND MEDICATION:

MEDICATION TO BE WITHHELD DURING STUDY? _____

7. SPECIAL NEEDS:

- LANGUAGE _____ CARE GIVER OR PARENT ACCOMPANIMENT
- AMBULATION _____ CARE ASSISTANCE _____

FOR OFFICE USE ONLY

- PSG MSLT TRIAGED (Med. Dir. Initials): _____ DATE: _____
- PAP TITRATION MWT URGENT
- PAP RE-TITRATION ADDITIONAL EQUIPMENT: S/S DATE: _____ CONSULT DATE: _____
- PAP (Starting) _____ cmH₂O _____ SPECIAL CONSIDERATIONS: _____
- PAP (Fixed) _____ cmH₂O _____