

REQUISITION

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

1. PATIENT INFORMATION

LAST _____
 FIRST _____
 DATE OF BIRTH _____
 MALE FEMALE
 HEALTH CARD NO. _____ VC _____
 ADDRESS _____
 _____ POSTAL CODE _____
 PHONE(HOME) (_____) _____
 PHONE(CELL) (_____) _____

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 DATE OF THE
LAST SLEEP STUDY _____

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 _____

6. ADDITIONAL COMMENTS AND MEDICATIONS:

FOR OFFICE USE ONLY

- PSG
- CPAP titration
- CPAP at home pressure of _____ all night
- MSLT
- MWT

 MEDICAL DIRECTOR SIGNATURE

S/S DATE: _____ CONSULT DATE: _____