NORTH YORK SLEEP & DIAGNOSTIC CENTRE
2 Champagne Drive, Unit B15
Toronto, ON, M3J 2C5
Tel: 416-642-4232 • Fax: 416-642-4234
info@northyorksleep.ca

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: _____ cmH_2O

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) _____ cmH_2O _____ SPECIAL CONSIDERATIONS: _____

☐ PAP (Fixed) _____ cmH_2O _____ _____