


PATIENT:

Address:

Phone (Home):

Phone (Cell):

Email:

Date of Birth:

 Male ☐

 Female ☐

Health Card #:

VC:

SLEEP STUDY REQUISITION

LOCATION:
URGENCY: Elective ☐ Semi-Urgent ☐ Urgent ☐
TEST REQUESTED:

- ☐ Diagnostic Sleep Study ONLY
☐ Diagnostic Sleep Study followed by CONSULT
☐ Consultation (tests as needed)
☐ CPAP/BiPAP Study (consult first as per OHIP)

Previous Sleep Study:

Has the Patient had a Previous Sleep Study elsewhere?

☐ Yes _____ (year) ☐ No

If YES, RESULTS MUST BE ATTACHED
PATIENT COMPLAINTS/SYMPTOMS: (Min. of 2 Symptoms)

- | | |
|---|--|
| ☐ difficulty falling asleep | ☐ snoring |
| ☐ frequent awakenings | ☐ apnea |
| ☐ unrefreshing sleep | ☐ repetitive movement in sleep |
| ☐ daytime somnolence/fatigue | ☐ restless legs, day/evening |
| ☐ recurrent headaches | ☐ parasomnia, abnormal behaviour in sleep |
| ☐ irresistible urge to sleep | ☐ Other _____ |

PROVISIONAL DIAGNOSIS:

- ☐ Sleep Apnea
☐ PLM / Restless Legs
☐ Narcolepsy/Hypersomnolence
☐ Chronic Insomnia
☐ Other _____

MEDICAL HISTORY:

- | | |
|---|---------------------------------------|
| ☐ Hypertension | ☐ Depression |
| ☐ Heart Disease | ☐ CNS |
| ☐ Asthma or COPD | ☐ Metabolic |
| ☐ Airway Surgery | ☐ Other: _____ |

CURRENT MEDICATIONS:

CURRENTLY ON:

 Oxygen: _____ LPM
 CPAP/BiPAP: _____ cmH₂O

SPECIAL NEEDS:

- ☐ Language Barrier
☐ requires attendant – parent/other
☐ ambulation restricted – wheelchair
☐ other _____

ALLERGIES:
OFFICE USE ONLY:

Book:

Medical Director:

 Referring Physician: _____
 (please print)

 Physician Signature: _____
 (required)

 Physician Number (billing): _____
 (required)

Date: _____

Address: _____

Phone: _____

Fax: _____

Mini Satisfaction Survey - Indicate on the scale your level of satisfaction and/or make a comment:

Unsatisfied _____ Very satisfied