THE SLEEP DISORDERS CLINIC

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☐ **Urgent**

☐ High Priority

☐ Routine

Incomplete Referrals (No Checks) will be Returned

☐ **Sleep study; consult; treatment if required**

☐ **Diagnostic sleep study only, no consult no treatment**

☐ **Consult; followed by diagnosis and treatment if required**

☐ **Level 3 Home Sleep Study (private pay)**

PATIENT'S NAME (last/ first): _____ DOB: _____ (DD/MM/YYYY)

ADDRESS: _____

HEALTH CARD NUMBER: _____ VERSION CODE: _____

PHONE NUMBER: _____ AFTER HOURS/ CELL: _____

PATIENT'S EMAIL ADDRESS: _____

REFERRING PHYSICIAN'S NAME: (PLEASE PRINT) _____

PHYSICIAN'S SIGNATURE: _____ PHYSICIAN'S BILLING NUMBER: _____

FAMILY DOCTOR (if different to referring doctor): _____

IMPORTANT: It is imperative that each section on this requisition be filled out as patients are prioritized according to severity of symptoms. Your office will be notified of the sleep study appointment/ office visit by mail. Please notify your patient of their appointment, our cancellation policy, and that they should check our website for instructions prior to attending the overnight appt.

Patient should be able to care for self in sleep lab. ☐ Problems with mobility ☐ Incontinence ☐ Urinary ☐ Fecal ☐ Communication (Hearing impaired, language, etc.) ☐ Developmental/Psychological Disorder ☐ History of Violence ☐ History of Seizure Disorder ☐ Infectious Disease ☐ TB ☐ MRSA ☐ VRE	Specify. _____ _____ _____ _____ ☐ Other _____
SYMPTOMS LEADING TO REFERRAL: ☐ Snoring ☐ Snoring with apnea ☐ Significantly overweight (BMI >30) Height Weight ☐ Unrefreshing sleep ☐ Excessive daytime sleepiness	☐ Frequent awakenings ☐ Difficulty initiating or maintaining sleep ☐ Restless legs ☐ Unusual movement during sleep ☐ Abnormal behaviour during sleep ☐ Other (specify) ☐ Oxygen _____ l/min
WORKING DIAGNOSIS: ☐ Sleep apnea ☐ Insomnia	☐ Narcolepsy ☐ Restless Legs Syndrome ☐ Other
OTHER MEDICAL DIAGNOSES: (Specify) ☐ Cardiac History ☐ DM	☐ Hypertension ☐ Medically Stable ☐ Other(specify) _____
☐ Patient has had a sleep study within past five years. ☐ Sleep study done more than five years ago. **Reports for studies done at other laboratories within past five years must be provided in order for a booking to be made.**	☐ Patient has been treated with CPAP in the past; not currently on CPAP treatment. ☐ Patient is currently on CPAP: current pressure _____ ☐ BIPAP IPAP___ cm H2O EPAP_____ cm H2O

Please provide a recent medication list or CPC.