FAX to 905-709-9995

SLEEP STUDY REQUISITION FORM

A sleep concierge will help select a location most convenient for you. Call (905) 707-5029

SERVICES REQUESTED:

- ❑ Sleep Specialist consultation only
- ❑ Sleep Specialist consultation, followed by titration sleep study (**previous sleep study before**)
- ❑ Sleep Study & Sleep Specialist consultation, followed by sleep titration study if results are abnormal (**no prior sleep study done before**)

PATIENT NAME _____
(PLEASE PRINT) (LAST) (FIRST)

OHIP _____ | | | ❑ NON-OHIP. DOB (D/M/Y) ____/____/____
VERSION CODE

SEX ❑ M ❑ F HEIGHT _____ (❑cm/ ❑ft) WEIGHT _____ (❑kg/❑lbs) BMI _____

ADDRESS _____

RES. NUMBER _____ CELL NUMBER _____ BUS. NUMBER _____

EMAIL ADDRESS _____ FAX NUMBER _____

PERSON TO NOTIFY IN CASE OF EMERGENCY _____ TEL. NUMBER _____
Available at Short Notice ❑ YES ❑ NO

REQUESTING PHYSICIAN

NAME _____ BILLING NUMBER _____
(PLEASE PRINT)

MAILING ADDRESS _____

TEL. NUMBER _____ FAX NUMBER _____

REASON FOR REFERRAL _____

- ❑ SNORING
- ❑ EXCESSIVE DAYTIME SLEEPINESS
- ❑ INSOMNIA
- ❑ ABNORMAL BEHAVIOUR DURING SLEEP
- ❑ OTHERS: _____
- ❑ WITNESSED APNEA
- ❑ MORNING HEADACHES or SORE THROAT
- ❑ RESTLESS LEGS/LEG CRAMPS
- ❑ FIBROMYALGIA/CHRONIC FATIGUE
- ❑ OBESITY

Other Medical Disorders: _____

Medications/Allergies: _____

Special Instructions: _____

Is the patient on Oxygen? ❑ YES ❑ NO Level _____ On CPAP ❑ YES ❑ NO Level_____
Does the patient understand English well enough to follow instructions? ❑ YES ❑ NO
IF NO, please ask patient to bring an interpreter
Is the patient a shift worker? ❑ YES ❑ NO Is it the 1st time the patient is having a sleep study? ❑ YES ❑ NO

PHYSICIAN SIGNATURE: _____ DATE: _____

Office Use Only:

APPOINTMENT DATE: _____ TIME: _____