Sleep Diagnostics Services
Experts In Sleep Management

935 3rd Ave SE,
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www.sleepdiagnosticservices.com

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?

PLEASE FILL IN ALL INFORM

☐NO ☐YES IF YES, PLEASE SPECIFY THE LAST SLEEP STUDY DATE: _____

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 _____

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:_____