



A SLEEP CLINIC WITH A DIFFERENCE

REQUISITION for SLEEP STUDIES & CONSULTATIONS

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Request for: Consultation & Sleep Assessment Sleep Consultation Sleep Study Only

Has the patient had any other sleep studies in the last 12 months? Yes No If so how many? _____

Note: * Patient may be scheduled directly into the sleep lab at the discretion of the laboratory physician or assigned to first available physician.

REFERRING PHYSICIAN:

Name: _____ OHIP Referral #: _____

Tel: () _____ Fax: () _____

Physician's Signature: _____ Date: (MM/DD/YR) ____/____/____

PATIENT INFORMATION:

Name: _____ D.O.B.: (MM/DD/YR) ____/____/____

Tel: () _____ Work/Cell: () _____

HIN#: _____

REASON FOR REFERRAL: PLEASE CHECK ALL THAT APPLY:

- Insomnia Circadian Disorder Excessive Daytime Sleepiness Narcolepsy Shift Work Sleep Disorder
- Snoring Sleep Apnea Restless Legs Syndrome Periodic Leg Movements Frequent Awakenings
- Sleep Walking/Talking/Abnormal Behaviours Nightmares Other _____

MEDICAL HISTORY: PLEASE CHECK ALL THAT APPLY:

- Hypertension CAD CHF MI Diabetes Migraines/Headaches Asthma/COPD Bruxism
- MVA/Accident Traumatic Brain Injury Seizure Disorder Parkinson's CVA IBS GERD
- Poor Memory/Concentration Chronic Pain Fibromyalgia Chronic Fatigue Syndrome Lyme Disease
- Mood Disorder Anxiety Disorder Panic Attacks OCD PTSD Other _____

CURRENT MEDICATIONS:

ALLERGIES: NKDA _____

COMMENTS: (Feel free to attach additional info.)

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Please check if you would like us to send you more referral forms.