

200 Fletcher Crescent Alliston, Ontario L9R 1W7 Tel: 705-435-5800 Fax: 705-435-5850

## REQUISITION FOR SLEEP STUDIES & CONSULTATIONS

Fax to 705-435-5850

Study Requested:		
Has the patient had any other sleep studies in the last 12 months?		
Note: * Patient may be scheduled directly into the sleep lab at the discretion of the laboratory physician or assigned to first available physician. If sleep study is chosen specialist will inform physician if consultation is recommended. **Patient requiring at throit will be brought in for a consultation as required by ministry guidelines.  REFERRING PHYSICIAN:  Name:  OHIP Referral #:  Tel #: ( )  Physician Signature:  Date: (yy/mm/dd)  PATIENT INFORMATION:  Name:  DOB: (yy/mm/dd)  Tel #: ( )  HIM#:  Cell #: ( )  REASON FOR REFERRAL: (please check all that apply)  Insomnia   Circadian Disorder   Excessive Daytime Sleepiness   Narcolepsy   Shift Work Sleep Disorder   Shoring   Sleep Walking/Talking/Abnormal Behaviours   Nightmares   Pre-Surgical Assessment to R/O OSA    Other		
* If sleep study is chosen specialist will inform physician if consultation as recommended. **Patient requiring a titration will be brought in for a consultation as required by ministry guidelines.  REFERRING PHYSICIAN:  Name:  Cell #: ( )  Physician Signature:  Date: (yy/mm/dd)  PATIENT INFORMATION:  Name:  DOB: (yy/mm/dd)  Tel #: ( )  HIN#:  Cell #: ( )  REASON FOR REFERRAL: (please check all that apply)  Insomnia   Circadian Disorder   Excessive Daytime Sleepiness   Narcolepsy   Shift Work Sleep Disorder   Snoring   Sleep Apnea   Restless Leg Syndrome   Periodic Leg Movements   Frequent Awakenings   Other  MEDICAL HISTORY: (please check all that apply)    HTN   CAD   CHF   MI   Diabetes   Migraines/Headaches   Asthma/COPD   Bruxism   MVA/Accident   Traumatic Brain Injury   Seizure Disorder   Parkinson's   CVA   IBS   GERD   Obesity   Poor Memory/Concentration   Chronic Pain   Fibromyalgia   Chronic Fatigue Syndrome   Lyme Disease   Current Medications:	Has the patient had any other sleep studies in the last 12 months?	
Name:  Tel #: (	* If sleep study is chosen specialist will inform physician if consultation is recommended.	
Physician Signature:  Date: (yy/mm/dd)  PATIENT INFORMATION:  Name:  DOB: (yy/mm/dd)  Tel #: (	REFERRING PHYSICIAN:	
PATIENT INFORMATION:  Name:  DOB: (yy/mm/dd)  Tel #: (	Name:	OHIP Referral #:
PATIENT INFORMATION:  Name:  DOB: (yy/mm/dd)  Tel #: (	Tel #: ( )	Fax #: ( )
Name:  Tel #: (	Physician Signature:	Date: (yy/mm/dd)
Name:  Tel #: (		
Tel #: ( )	PATIENT INFORMATION:	
REASON FOR REFERRAL: (please check all that apply)    Insomnia   Circadian Disorder   Excessive Daytime Sleepiness   Narcolepsy   Shift Work Sleep Disorder   Snoring   Sleep Apnea   Restless Leg Syndrome   Periodic Leg Movements   Frequent Awakenings   Sleep Walking/Talking/Abnormal Behaviours   Nightmares   Pre-Surgical Assessment to R/O OSA   Other   MEDICAL HISTORY: (please check all that apply)   HTN   CAD   CHF   MI   Diabetes   Migraines/Headaches   Asthma/COPD   Bruxism   MVA/Accident   Traumatic Brain Injury   Seizure Disorder   Parkinson's   CVA   IBS   GERD   Obesity   Poor Memory/Concentration   Chronic Pain   Fibromyalgia   Chronic Fatigue Syndrome   Lyme Disease   Mood Disorder   Anxiety Disorder   Panic Attacks   OCD   PTSD   Current Medications:	Name:	DOB: (yy/mm/dd)
REASON FOR REFERRAL: (please check all that apply)    Insomnia	Tel #: ( )	Work #: ( )
□ Insomnia       □ Circadian Disorder       □ Excessive Daytime Sleepiness       □ Narcolepsy       □ Shift Work Sleep Disorder         □ Snoring       □ Sleep Apnea       □ Restless Leg Syndrome       □ Periodic Leg Movements       □ Frequent Awakenings         □ Sleep Walking/Talking/Abnormal Behaviours       □ Nightmares       □ Pre-Surgical Assessment to R/O OSA         □ Other       ■ MEDICAL HISTORY: (please check all that apply)         □ HTN       □ CAD       □ CHF       □ MI       □ Diabetes       □ Migraines/Headaches       □ Asthma/COPD       □ Bruxism         □ MVA/Accident       □ Traumatic Brain Injury       □ Seizure Disorder       □ Parkinson's       □ CVA       □ IBS       □ GERD       □ Obesity         □ Poor Memory/Concentration       □ Chronic Pain       □ Fibromyalgia       □ Chronic Fatigue Syndrome       □ Lyme Disease         □ Mood Disorder       □ Anxiety Disorder       □ Panic Attacks       □ OCD       □ PTSD       □         Current Medications:	HIN#:	Cell #: ( )
□ Insomnia       □ Circadian Disorder       □ Excessive Daytime Sleepiness       □ Narcolepsy       □ Shift Work Sleep Disorder         □ Snoring       □ Sleep Apnea       □ Restless Leg Syndrome       □ Periodic Leg Movements       □ Frequent Awakenings         □ Sleep Walking/Talking/Abnormal Behaviours       □ Nightmares       □ Pre-Surgical Assessment to R/O OSA         □ Other       ■ MEDICAL HISTORY: (please check all that apply)         □ HTN       □ CAD       □ CHF       □ MI       □ Diabetes       □ Migraines/Headaches       □ Asthma/COPD       □ Bruxism         □ MVA/Accident       □ Traumatic Brain Injury       □ Seizure Disorder       □ Parkinson's       □ CVA       □ IBS       □ GERD       □ Obesity         □ Poor Memory/Concentration       □ Chronic Pain       □ Fibromyalgia       □ Chronic Fatigue Syndrome       □ Lyme Disease         □ Mood Disorder       □ Anxiety Disorder       □ Panic Attacks       □ OCD       □ PTSD       □         Current Medications:		
Sleep Walking/Talking/Abnormal Behaviours   Nightmares   Pre-Surgical Assessment to R/O OSA      Other     MEDICAL HISTORY: (please check all that apply)	REASON FOR REFERRAL: (please check all that apply)	
Sleep Walking/Talking/Abnormal Behaviours	☐ Insomnia ☐ Circadian Disorder ☐ Excessive Daytime Sleepiness ☐ Narcolepsy ☐ Shift Work Sleep Disorder	
MEDICAL HISTORY: (please check all that apply)  HTN	☐ Snoring ☐ Sleep Apnea ☐ Restless Leg Syndrome ☐ Periodic Leg Movements ☐ Frequent Awakenings	
MEDICAL HISTORY: (please check all that apply)  HTN CAD CHF MI Diabetes Migraines/Headaches Asthma/COPD Bruxism  MVA/Accident Traumatic Brain Injury Seizure Disorder Parkinson's CVA IBS GERD Obesity  Poor Memory/Concentration Chronic Pain Fibromyalgia Chronic Fatigue Syndrome Lyme Disease  Mood Disorder Anxiety Disorder Panic Attacks OCD PTSD  Current Medications:	☐ Sleep Walking/Talking/Abnormal Behaviours ☐ Nightmares ☐ Pre-Surgical Assessment to R/O OSA	
HTN       CAD       CHF       MI       Diabetes       Migraines/Headaches       Asthma/COPD       Bruxism         MVA/Accident       Traumatic Brain Injury       Seizure Disorder       Parkinson's       CVA       IBS       GERD       Obesity         Poor Memory/Concentration       Chronic Pain       Fibromyalgia       Chronic Fatigue Syndrome       Lyme Disease         Mood Disorder       Anxiety Disorder       Panic Attacks       OCD       PTSD	☐ Other	
HTN       CAD       CHF       MI       Diabetes       Migraines/Headaches       Asthma/COPD       Bruxism         MVA/Accident       Traumatic Brain Injury       Seizure Disorder       Parkinson's       CVA       IBS       GERD       Obesity         Poor Memory/Concentration       Chronic Pain       Fibromyalgia       Chronic Fatigue Syndrome       Lyme Disease         Mood Disorder       Anxiety Disorder       Panic Attacks       OCD       PTSD		
MVA/Accident	MEDICAL HISTORY: (please check all that apply)	
Poor Memory/Concentration	☐ HTN ☐ CAD ☐ CHF ☐ MI ☐ Diabetes ☐ Migraines/Headaches ☐ Asthma/COPD ☐ Bruxism	
Mood Disorder Anxiety Disorder Panic Attacks OCD PTSD Current Medications:	☐ MVA/Accident ☐ Traumatic Brain Injury ☐ Seizure Disorder ☐ Parkinson's ☐ CVA ☐ IBS ☐ GERD ☐ Obesity	
Current Medications:	☐ Poor Memory/Concentration ☐ Chronic Pain ☐ Fibromyalgia ☐ Chronic Fatigue Syndrome ☐ Lyme Disease	
	☐ Mood Disorder ☐ Anxiety Disorder ☐ Panic Attacks ☐ OCD ☐ PTSD ☐	
Allergies:	Current Medications:	
Allergies:		
Allergies:		
Allergies:		*
	Allergies:	

