



200 Fletcher Crescent
 Alliston, Ontario L9R 1W7
 Tel: 705-435-5800
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STEVENSON
 MEMORIAL HOSPITAL

REQUISITION FOR SLEEP STUDIES & CONSULTATIONS

Fax to 705-435-5850

Study Requested: <input type="checkbox"/> PSG	<input type="checkbox"/> CPAP Titration	<input type="checkbox"/> Bi-Level Titration
Request for: <input type="checkbox"/> Consultation & Sleep Assessment	<input type="checkbox"/> Sleep Consultation	<input type="checkbox"/> Sleep Study Only
Has the patient had any other sleep studies in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No		

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 a titration will be brought in for a consultation as required by ministry guidelines.

REFERRING PHYSICIAN:	
Name:	OHIP Referral #:
Tel #: ()	Fax #: ()
Physician Signature:	Date: (yy/mm/dd)

PATIENT INFORMATION:	
Name:	DOB: (yy/mm/dd)
Tel #: ()	Work #: ()
HIN#:	Cell #: ()

REASON FOR REFERRAL: (please check all that apply)	
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Circadian Disorder
<input type="checkbox"/> Excessive Daytime Sleepiness	<input type="checkbox"/> Narcolepsy
<input type="checkbox"/> Shift Work Sleep Disorder	<input type="checkbox"/> Snoring
<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Restless Leg Syndrome
<input type="checkbox"/> Periodic Leg Movements	<input type="checkbox"/> Frequent Awakenings
<input type="checkbox"/> Sleep Walking/Talking/Abnormal Behaviours	<input type="checkbox"/> Nightmares
<input type="checkbox"/> Pre-Surgical Assessment to R/O OSA	<input type="checkbox"/> Other _____

MEDICAL HISTORY: (please check all that apply)	
<input type="checkbox"/> HTN	<input type="checkbox"/> CAD
<input type="checkbox"/> CHF	<input type="checkbox"/> MI
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Migraines/Headaches
<input type="checkbox"/> Asthma/COPD	<input type="checkbox"/> Bruxism
<input type="checkbox"/> MVA/Accident	<input type="checkbox"/> Traumatic Brain Injury
<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Parkinson's
<input type="checkbox"/> CVA	<input type="checkbox"/> IBS
<input type="checkbox"/> GERD	<input type="checkbox"/> Obesity
<input type="checkbox"/> Poor Memory/Concentration	<input type="checkbox"/> Chronic Pain
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Chronic Fatigue Syndrome
<input type="checkbox"/> Lyme Disease	<input type="checkbox"/> Mood Disorder
<input type="checkbox"/> Anxiety Disorder	<input type="checkbox"/> Panic Attacks
<input type="checkbox"/> OCD	<input type="checkbox"/> PTSD
<input type="checkbox"/> _____	

Current Medications:

Allergies:

