STEVENSON
MEMORIAL HOSPITAL

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: ☐ PSG ☐ CPAP Titration ☐ Bi-Level Titration
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

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)

☐ 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:

Allergies: