Soldiers' MEMORIAL HOSPITAL Orillia

Apply Patient Label Here with min. of Name, DOB, Health Card #

Sleep Study Requisition Form

Note: Incomplete or illegible forms will be sent back requesting amendment

Patient Information:

Patient Name		
Patient DOB		Male: ☐ Female: ☐
Primary Phone #		
Health Card # & Version Code		
OSMH MRN (if applicable)		

Select Test & Urgency Requested:

☐ Initial Diagnostic Sleep Study (first ever in Ontario*)

☐ Initial Diagnostic Sleep Study (first ever in Ontario*) and consultation in CPAP Clinic (in the event of positive findings of Obstructive Sleep Apnea)

☐ Repeat Diagnostic Sleep Study including pre-study physician consult*

☐ CPAP Titration Sleep Study including pre-study physician consult*

**Per OHIP Schedule of Benefits*

Select Urgency: ☐ Routine ☐ Urgent (comment): _____

Reason for Referral:

☐ Snoring
☐ Excessive Daytime Sleepiness
☐ Reassess CPAP
☐ Sleep Apnea
☐ Periodic Limb Movements/Restless Legs
☐ Other: _____

Pulmonary History: _____

☐ ↑ PaCO2 ☐ Pt receiving home O2 @ _____ lpm

Cardiac History: _____

☐ CHF ☐ Hypertension ☐ Arrhythmias (Specify) _____

Other Medical conditions: _____

Current Medications: _____

Height: _____ Weight: _____ Smoking: Yes ☐ No ☐ PPT Hx_____

Caffeine Consumption per day: Coffee _____ Cola _____ Tea _____

Alcohol: Yes ☐ No ☐ Quit ☐ (# week average _____)

Referral Physician:

Date Sent		
Referring Physician	Physician Name (print): _____ Physician Signature: _____ Physician CPSO #: _____	
Office Telephone #		Fax: