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

Select Test & Urgency Requested:

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

☐ Initial Diagnostic Sleep Study (first ever in Ontario*) & consultation in CPAP Clinic (if 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 ☐ Sleep Apnea

☐ Excessive Daytime Sleepiness ☐ Periodic Limb Movements/Restless Legs

☐ Reassess CPAP ☐ Other: ______________________________

Pulmonary History: ______________________________

☐ ↑ $PaCO_2$ ☐ Pt receiving home O_2 @ __________ lpm

Cardiac History: ______________________________

☐ CHF ☐ Hypertension ☐ Arrhythmias (Specify) ______________________________

Other Medical conditions: ______________________________

Current Medications: ______________________________

____

Caffeine Consumption per day: Coffee ____ Cola____ Tea ____ Alcohol: Yes ☐ (week avg ____) No ☐ Quit ☐

Height: _______ Weight: _______ Neck Size: _________

Smoking: Yes ☐ No ☐ PPY Hx __________ Comments: ______________________________

____

Referral Physician:

Date Sent		
Referring Physician	Physician Name (print): ____________________ Physician CPSO #: __________ Physician Signature: ______________________________	
Office Telephone #		Fax: