Hawkesbury Sleep & Diagnostic Centre

REQUISITION for SLEEP STUDY & CONSULTATION

☒ **Consultation* & Sleep Study & Titration (if required)****

Has the patient had any other sleep studies in the last 12 months? ☐ Yes ☐ No If so how many? ____

Note: Patient may be scheduled directly into the sleep lab at the discretion of the laboratory physician or assigned to first available physician.*Consultation requirements will be assessed after the results of the test. **Patient requiring a titration will be brought in for a consultation as required by ministry guidelines.

REFERRING PHYSICIAN:

Name: _____ OHIP Referral #: _____
Tel: ( ) _____ Fax: ( ) _____

Physician's Signature: _____ Date: (MM/DD/YR) _____/_____/ _____

PATIENT INFORMATION:

Name: _____ D.O.B.: (MM/DD/YR) ____/_____/_____
Tel: ( ) _____ Work/Cell: ( ) _____
HIN#: _____

REASON FOR REFERRAL: *PLEASE CHECK ALL THAT APPLY:*

☐ **Insomnia** ☐ **Circadian Disorder** ☐ **Excessive Daytime Sleepiness** ☐ **Narcolepsy** ☐ **Shift Work Sleep Disorder**
☐ **Snoring** ☐ **Sleep Apnea** ☐ **Restless Legs 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: _____

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