Please Fill In Requisition As Completely As Possible

Oakville Trafalgar Memorial Hospital
3001 Hospital Gate, Oakville, ON L6M 0L8
Phone: 905-338-4484 Fax: 905-815-5082

SLEEP LABORATORY REQUISITION

URGENCY: ❒ Elective ❒ Urgent

Reason for Urgency

Reason for Referral

Patient Name: _____

Address: _____

_____

Phone (Home): _____

(Business): _____

Date of Birth: _____ ❒ M ❒ F

Health Card # : _____

Unit#: _____

TEST REQUESTED: ❒ Request for Consultation

❒ Initial Diagnostic Sleep Study (1/lifetime) ❒ Repeat Diagnostic Sleep Study

❒ Therapeutic Study:

❒ CPAP Titration ❒ BiPap Titration ❒ Other: _____

❒ Split Study

Appointment Date	**Time**

Day Study Requested: ❒ Yes ❒ No

Has the patient EVER had a Sleep Study? ❒ No ❒ Yes **– DD/MM/YY** _____

NOTE: **Prior written approval is necessary for some tests due to limits set by OHIP/Ministry of Health** **Requested: ❒ Yes ❒ No** **Attached: ❒ Yes ❒ No**

PATIENT SYMPTOMS

❒ Snoring	❒ Daytime Restless Legs	❒ Frequent Awakenings	❒ Other:
❒ Snoring with Apnea	❒ Repetitive Movement During Sleep	❒ Daytime Sleepiness	_____
❒ Unrefreshing Sleep	❒ Abnormal Behaviour During Sleep	❒ Irresistible Urge to Fall Asleep	_____
❒ Difficulty Falling Asleep	❒ Difficulty Staying Asleep	❒ Fatigue	

MEDICAL HISTORY

❒ Yes ❒ No Hypertension

❒ Yes ❒ No Heart Disease

❒ Yes ❒ No Asthma or Chronic Bronchitis/COPD

❒ Yes ❒ No Airway Surgery

❒ Yes ❒ No Depression

CNS: _____

Metabolic: _____

Other Health Problems: _____

COMMENTS: _____

_____

_____

CURRENT MEDICATIONS – Dose / x / Day

_____ _____ _____

_____ _____ _____

_____ _____ _____

Drug Allergies: _____

CURRENTLY ON

Oxygen _____ L/min CPAP _____ cm H_2O ❒ Bipap IPAP _____cm H_2O EPAP _____ cm H_2O ❒ Auto Unit

SPECIAL CARE NEEDS (e.g. Patient requires extra assistance or support worker during study)	**Weight** _____ Kg / lbs	**Height**

Physician Signature: _____

Physician Name (Print): _____

Date: _____

cc: _____

cc: _____

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