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PLEASE FAX: 1-888-477-7739

Email to: info@cpapclinic.ca

REQUISITION FOR: ☐ **Routine** ☐ **Urgent, Reason** _____

☐ **At-Home Sleep Study** ☐ **In-Lab Sleep Study** ☐ **CPAP Titration** ☐ **Consult Only**

Patient's Name (Please Print) _____ _____
LAST FIRST

OHIP # _____ Date of Birth (D/M/Y) _____ Sex : ☐ M ☐ F

Address _____ City _____ Postal Code _____

Email _____ Bus. ( ) _____ Cell. ( ) _____

REASONS FOR REFERRAL

☐ Snoring ☐ Insomnia ☐ Excessive Daytime Sleepiness (EDS)

☐ Restless Legs ☐ Witnessed Apnea ☐ Morning Headaches

☐ Non-restorative Sleep ☐ Chronic Fatigue ☐ Others _____

MEDICAL HISTORY

Medications: _____

Do you require any medication to be held for the sleep study: ☐ No ☐ Yes _____

Allergies: ☐ _____

Has This Patient Had a Sleep Study Done Previously?

☐ Yes ☐ No ☐ Unknown *If Yes, Please State Date and Location* _____

Special Needs: ☐ Communication ☐ Hearing ☐ Mobility ☐ Other _____

Is Patient on Oxygen? ☐ No ☐ Yes L/minute _____ ☐ Night-time Only ☐ Day and Night

Patient on CPAP? ☐ No ☐ Yes cm H_2O _____

REQUESTING PHYSICIAN

Name (Please Print) _____ Physician No. _____

Mailing Address: _____

Telephone Number ( ) _____ Fax Number ( ) _____

Physician's Signature: _____ Date of Request (D/M/Y) _____

CC to Dr.: _____ Date: _____