**Sleep Study & Sleep Apnea Treatment**

***Requisition Form***

# REFERRING DOCTOR

Referring Physician: Dr. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Billing #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_—\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_\_—\_\_\_\_\_\_\_\_\_\_\_\_\_

Email (optional): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MM DD YYYY

# PATIENT DEMOGRAPHIC

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OHIP #: \_\_\_\_\_\_\_\_—\_\_\_\_\_\_\_\_—\_\_\_\_\_\_\_\_\_\_ Version Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender:  Male  Female  Other

MM DD YYYY

Contact Phone #: (\_\_\_\_\_) \_\_\_\_\_\_\_—\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is Patient a Current PAP Machine User?**  Yes  No

If yes, date of last sleep test: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # of Years on PAP Therapy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

MM DD YYYY

# REASON(S) FOR REFERRAL

Sleep Study & Consultation. Please specify:  Sleep Consultation Only

( ) Diagnostic Sleep Study  Home Study\* *(\*not covered by OHIP)*

( ) PAP Machine Titration  PAP Machine Re-Assessment

# SYMPTOMS

Snoring / Suspected Sleep Apnea  Insomnia

Cardiovascular Risk Factors  Abnormal Sleep Pattern

Excessive Daytime Sleepiness  Restless Leg

Narcolepsy  Others: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# RELEVANT MEDICAL INFORMATION AND HISTORY

MI / CAD  Seizures / Epilepsy  GERD  CHF

Diabetes  Stroke  Asthma / COPD  Hypertension

Cardiac Arrythmia  Glaucoma  Others: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Urgency / Safety Critical Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Special Needs (Difficulty Communicating / Accessibility): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

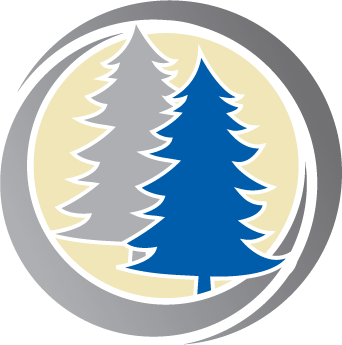
**Woodbine Medical Centre**

7155 Woodbine Ave., Main Level, Unit 108

Markham, Ontario, L3R 1A3

Tel: (416) 628-4012 Fax: (416) 628-4006

Email: info@mycpap.ca Web: www.mycpap.ca



****

**HEALTHY SLEEP**

**CLINIC**