**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**