



SLEEP STUDY REQUISITION

Referral Type

- Initial Sleep Study only (first ever sleep study)
Initial Sleep Study followed by Consultation if significant abnormality (first ever sleep study)
Repeat Sleep Study (sleep physician consultation/assessment prior to study)
Consultation only

Indication for Referral

- Snoring Suspected sleep apnea Chronic insomnia Daytime sleepiness
Unexplained fatigue Non-restorative sleep Restless legs/Leg movement disorder during sleep
Atrial fibrillation Congestive heart failure Other
Urgent study required

Patient Information

Patient's Name Last name First name M F
Address Number and Street Name Apt. # City Postal Code
Home Phone Daytime/Work Phone Cell Phone
Date of Birth Day Month Year Health Card
Email Relevant Medical Conditions
Medications
Special Needs Language Care Giver Has patient had prior sleep testing? Date
Requirements Ambulation Care Assistance Location

Referring Physician Information

Referring Physician Full Name and Initials OHIP Billing #
Telephone Fax
Address Number and Street Name Suite Number City Postal Code
Copies to: Email (optional)
Signature

Approved by Sleep Physician Date Urgent

Special Considerations