YORK COUNTY SLEEP DISORDERS CENTRE
28 Main St. North, Newmarket ON
Tel: 905-895-3487 Email: sdclab@rogers.com
Fax: 905-895-5364

CLEAR FORM

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 _____ ☐ M ☐ F
(Last name, First name)

Address _____
(Number and Street Name, Apt. #, City, Postal Code)

Home Phone _____ Daytime/Work Phone _____ Cell Phone _____

Date of Birth _____ Health Card _____
(Day, Month, Year)

Email _____ Relevant Medical Conditions _____

_____

_____

Medications _____

Special Needs Requirements ☐ Language ☐ Care Giver ☐ Ambulation ☐ Care Assistance

Has patient had prior sleep testing? Date _____

Location _____

Referring Physician Information

Referring Physician _____ OHIP Billing # _____
(Full Name and Initials)

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 _____

This requisition form can be taken to any licensed facility providing health care services including hospitals accepting community referrals and community surgical and diagnostic centres, such as those listed on the website: Community surgical and diagnostic centres | ontario.ca