Richmond Hill SLEEP AND LUNG INSTITUTE

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SLEEP LABORATORY REQUISITION

PATIENT INFORMATION

Name: _____ Health Card #: _____
DOB (dd/mm/yyyy): _____ Age: _____ Gender: _____
Address: _____ City: _____ Postal Code: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-mail: _____

STUDY REQUESTED

☐ *Urgent. Reason:* _____

☐ Sleep Study and Consult if Significant Sleep Apnea ☐ CPAP Titration
☐ Sleep Study Only ☐ Split-Night Study _____
☐ Sleep Study and Consultation ☐ MSLT
☐ Consultation ☐ MWT

☐ Overnight oximetry for _____ nights on: ☐ Room Air ☐ O2 _____ LPM ☐ CPAP of _____

ADULT ASSESSMENT (≥ 13 years of age)
☐ First Available ☐ Dr. T Abdelshaheed ☐ Dr. V Chan ☐ Dr. F Liu ☐ Dr. J Zurawska

PEDIATRIC ASSESSMENT (4 to 12 years of age)
☐ First Available ☐ Pediatric Respirologist

HAS PATIENT EVER HAD A PREVIOUS SLEEP STUDY? ☐ ***No*** ☐ ***Yes, Date/Location:*** _____

CLINICAL INFORMATION

Reason for Referral: _____

☐ Snoring ☐ Difficulty Falling Asleep ☐ Nocturnal Seizures
☐ Witnessed Apnea ☐ Difficulty Staying Asleep ☐ Tonsillar/Adenoid Hypertrophy
☐ Non-restorative Sleep ☐ CPAP Follow-Up ☐ Abnormal Movements in Sleep/Sleep Walk
☐ Daytime Sleepiness ☐ Restless Legs ☐ Poor Attention/Concentration/Hyperactivity
☐ Other _____

MEDICAL HISTORY

☐ Heart Disease ☐ COPD/Asthma ☐ ADHD ☐ Craniofacial Anomaly
☐ Hypertension ☐ Pulmonary Hypertension ☐ Autism ☐ Prader-Willi Syndrome
☐ Arrhythmia ☐ Renal Failure ☐ Trisomy 21 ☐ Congenital Heart Ds
☐ Stroke ☐ Seizure Disorder ☐ Achondroplasia ☐ Other Congenital
☐ Other _____

Current medications: _____

SPECIAL ASSISSTANCE

☐ Caregiver/Parental Accompaniment ☐ Wheelchair Dependent
☐ Translation Required. Language: _____ ☐ Home Oxygen _____ L/min

REFERRING PHYSICIAN

Signature: _____ Date: _____
Name: _____ Billing #: _____
Phone: _____ Fax: _____
Copies To: _____ Family MD: _____