BURLINGTON SLEEP MEDICINE CENTRE
Kitchener-Cambridge Office
51 Breithaupt Street, Suite 100, Kitchener, ON N2H 5G5
Office: (519) 804-9892 **Fax: (519) 804-9236**

SLEEP STUDY REQUISITION

Please Complete All Sections in Full

1. PATIENT INFORMATION

LAST ____________________

FIRST ____________________

DATE OF BIRTH ____________________
DD/MM/YYYY

☐ MALE ☐ FEMALE

HEALTH CARD NO. ________________ VC___

ADDRESS ____________________

________________ POSTAL CODE ________

PHONE(HOME) (_______)________________

PHONE(CELL) (_______)________________

2. REQUEST FOR:

☐ ROUTINE ☐ URGENT

☐ SLEEP STUDY AND CONSULTATION

☐ SLEEP STUDY ONLY

☐ CONSULTATION ONLY

IMPORTANT: HAS A SLEEP STUDY BEEN DONE PREVIOUSLY HERE OR AT ANY OTHER FACILITY?

☐NO ☐YES IF YES, PLEASE SPECIFY THE DATE OF THE LAST SLEEP STUDY / WHERE ________________

(ATTACH PREVIOUS RESULTS IF AVAILABLE)

CLINICAL INFORMATION

3. REASON FOR REFERRAL:

*** A minimum of 2 symptoms required for sleep study**

☐ SNORING ☐ INSOMNIA

☐ SUSPECTED OSA ☐ RESTLESS LEGS

☐ EXCESSIVE DAYTIME SLEEPINESS

☐ NARCOLEPSY (REQUIRES DAYTIME TEST)

☐ ABNORMAL SLEEP BEHAVIOUR (SLEEP WALKING/TALKING)

☐ OTHER:________________________

4. RELEVANT MEDICAL HISTORY

IS PATIENT ON CPAP?

☐ NO ☐ YES: __________ cmH_2O

IS PATIENT ON OXYGEN?

☐ NO ☐ YES: __________ L/M

☐ AT NIGHT ONLY ☐ DAY AND NIGHT

OTHER: ________________________

____

5. REFERRING PHYSICIAN INFORMATION

NAME ____________________

OHIP BILLING NO. ____________________

ADDRESS ____________________

PHONE (___)__________ FAX (___)__________

COPY TO ____________________

SIGNATURE ____________________

6. ADDITIONAL COMMENTS AND MEDICATIONS LIST:

____

____

____

____

FOR OFFICE USE ONLY

☐ PSG
☐ CPAP titration
☐ CPAP at home pressure of ______ all night
☐ MSLT
☐ MWT

____
MEDICAL DIRECTOR SIGNATURE

S/S DATE:____________ CONSULT DATE:____________

RESULTS RETURNED WITHIN TWO WEEKS