PLEASE FAX: 1-888-477-7739

Email to: info@cpapclinic.ca

REQUISITION FOR: ☐ **Routine** ☐ **Urgent, Reason**____

☐ **At-Home Sleep Study** ☐ **In-Lab Sleep Study** ☐ **CPAP Titration** ☐ **Consult Only**

Patient's Name (Please Print) ____________________________ ____________________________

LAST FIRST

OHIP # __________________________ Date of Birth (D/M/Y) ____________________ Sex : ☐ M ☐ F

Address ____________________________________ City _________________ Postal Code__________

Email ________________________________ Bus. ( ) ___________ Cell. ( ) ____________

REASONS FOR REFERRAL

☐ Snoring ☐ Insomnia ☐ Excessive Daytime Sleepiness (EDS)

☐ Restless Legs ☐ Witnessed Apnea ☐ Morning Headaches

☐ Non-restorative Sleep ☐ Chronic Fatigue ☐ Others ______________________________

MEDICAL HISTORY

Medications: ____

Do you require any medication to be held for the sleep study: ☐ No ☐ Yes ____________________________

Allergies: ☐ ____

Has This Patient Had a Sleep Study Done Previously?

☐ Yes ☐ No ☐ Unknown *If Yes, Please State Date and Location* ____________________________

Special Needs: ☐ Communication ☐ Hearing ☐ Mobility ☐ Other ____________________

Is Patient on Oxygen? ☐ No ☐ Yes L/minute ______________ ☐ Night-time Only ☐ Day and Night

Patient on CPAP? ☐ No ☐ Yes cm H_2O ______________

REQUESTING PHYSICIAN

Name (Please Print) ____ Physician No. ____________________

Mailing Address: ____

Telephone Number ( ) _________________________ Fax Number ( ) ________________________

Physician's Signature: ______________________________ Date of Request (D/M/Y) ____________________

CC to Dr.: ____ Date: ______________________