



**SLEEP CENTRE REQUISITION**

499 Raglan Street North

RENFREW, Ontario K7V 1P6

Telephone: 613-432-4851 ext 158; Fax: 613-433-5705

**Please Complete in Full**

Surname: \_\_\_\_\_ Given Name: \_\_\_\_\_ Date of Birth: y/m/d \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Provincial Insurance Number \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone No.: \_\_\_\_\_ Address: \_\_\_\_\_ Referring Physician's Signature \_\_\_\_\_

**Please Indicate Level of Request:**

- Sleep study followed by NCPAP and sleep specialist consultation (if indicated by the PSG results).
- Overnight Sleep Study only.
- CPAP / BIPAP titration.
- Overnight Sleep Study to assess nocturnal saturation.

**Reason for Referral:**

- Snoring; rule out sleep apnea.
- Sleepy.
- Overwhelming sleepiness.
- Restless legs / periodic leg movements
- Other (please specify): \_\_\_\_\_

**Special Needs** (e.g. Wheelchair bound, amputation)

- Needs assistance getting out of bed
- On Oxygen
- Nocturnal angina
- Needs assistance dressing
- Mentally challenged

**\* Sleep related medications should usually be stopped at least one month prior to sleep study, unless the discontinuation is medically or psychiatrically contraindicated.**

- Check here if you wish to have your patient studied on usual medications.

Please list current medications: