Sleep Study & Sleep Apnea Treatment

Requisition Form

REFERRING DOCTOR

Referring Physician: Dr. _____ Billing #: _____

Phone: (_____) _____—_____ Fax: (_____) _____—_____

Email (optional): _____

Signature: _____ Date: _____
MM DD YYYY

PATIENT DEMOGRAPHIC

First Name: _____ Last Name: _____

OHIP #: _____—_____—_____ Version Code: _____

DOB: _____ Gender: ☐ Male ☐ Female ☐ Other
MM DD YYYY

Contact Phone #: (_____) _____—_____

Is Patient a Current PAP Machine User? ☐ Yes ☐ No

If yes, date of last sleep test: _____ # of Years on PAP Therapy: _____
MM DD YYYY

REASON(S) FOR REFERRAL

☐ Sleep Study & Consultation. Please specify:

( ) Diagnostic Sleep Study

( ) PAP Machine Titration

☐ Sleep Consultation Only

☐ Home Study* *(*not covered by OHIP)*

☐ PAP Machine Re-Assessment

SYMPTOMS

☐ Snoring / Suspected Sleep Apnea

☐ Cardiovascular Risk Factors

☐ Excessive Daytime Sleepiness

☐ Narcolepsy

☐ Insomnia

☐ Abnormal Sleep Pattern

☐ Restless Leg

☐ Others: _____

RELEVANT MEDICAL INFORMATION AND HISTORY

☐ MI / CAD ☐ Seizures / Epilepsy ☐ GERD ☐ CHF

☐ Diabetes ☐ Stroke ☐ Asthma / COPD ☐ Hypertension

☐ Cardiac Arrythmia ☐ Glaucoma ☐ Others: _____

Medication(s): _____

Urgency / Safety Critical Occupation: _____

Special Needs (Difficulty Communicating / Accessibility): _____

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Orillia CPAP HEALTHY SLEEP