

Please Fill In Requisition As Completely As Possible



Oakville Trafalgar Memorial Hospital
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SLEEP LABORATORY REQUISITION

URGENCY: ☐ Elective ☐ Urgent

Reason for Urgency

Reason for Referral

Patient Name: _____

Address: _____

Phone (Home): _____

(Business): _____

Date of Birth: _____ ☐ M ☐ F

Health Card # : _____

Unit#: _____

TEST REQUESTED: ☐ Request for Consultation

☐ Initial Diagnostic Sleep Study (1/lifetime) ☐ Repeat Diagnostic Sleep Study

☐ Therapeutic Study:

☐ CPAP Titration ☐ BiPap Titration ☐ Other: _____

☐ Split Study

Appointment Date

Time

Day Study Requested: ☐ Yes ☐ No

Has the patient EVER had a Sleep Study? ☐ No ☐ Yes – DD/MM/YY _____

NOTE: Prior written approval is necessary for some tests due to limits set by OHIP/Ministry of Health

Requested: ☐ Yes ☐ No

Attached: ☐ Yes ☐ No

PATIENT SYMPTOMS

- | | | | |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Daytime Restless Legs | <input type="checkbox"/> Frequent Awakenings | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Snoring with Apnea | <input type="checkbox"/> Repetitive Movement During Sleep | <input type="checkbox"/> Daytime Sleepiness | _____ |
| <input type="checkbox"/> Unrefreshing Sleep | <input type="checkbox"/> Abnormal Behaviour During Sleep | <input type="checkbox"/> Irresistible Urge to Fall Asleep | _____ |
| <input type="checkbox"/> Difficulty Falling Asleep | <input type="checkbox"/> Difficulty Staying Asleep | <input type="checkbox"/> Fatigue | _____ |

MEDICAL HISTORY

- | | |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Hypertension | <input type="checkbox"/> Yes <input type="checkbox"/> No Depression |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease | CNS: _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma or Chronic Bronchitis/COPD | Metabolic: _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Airway Surgery | Other Health Problems: _____ |

COMMENTS: _____

CURRENT MEDICATIONS – Dose / x / Day

_____	_____	_____
_____	_____	_____
_____	_____	_____

Drug Allergies: _____

CURRENTLY ON

Oxygen _____ L/min CPAP _____ cm H₂O ☐ Bipap IPAP _____ cm H₂O EPAP _____ cm H₂O ☐ Auto Unit

SPECIAL CARE NEEDS (e.g. Patient requires extra assistance or support worker during study)

Weight

Height

_____ Kg / lbs

Physician Signature: _____

Date: _____

cc: _____

Physician Name (Print): _____

cc: _____

