Trillium Health Partners
Better Together

# SLEEP STUDY REQUISITION

**PLEASE FAX COMPLETED FORM TO: 905-813-4175**

**SPECIAL NEEDS – IMPORTANT TO COMPLETE**
**Nursing is not available in the Sleep Lab**

- □ Ambulatory
- □ Requires a caregiver / PSW all of the time
- □ Requires constant assistance to ambulate
- □ Requires assistance with toileting
- □ Requires a wheelchair all of the time
- □ Other _____

_____

| **Patient Name:** | Phone: | Work: |
|---|---|---|
| Address: | City: | Postal Code: |
| Health Card # : | Date of Birth: | CVH#: |
| **Referring Physician:** | | |
| Signature: | OHIP billing #: | |
| Copies To: | | |

**Clinical Information:** ☐ URGENT ☐ ELECTIVE PREVIOUS SLEEP STUDY* ☐ NO ☐ YES

* In compliance with MOHLTC patients who have previously had sleep studies, will be seen in consult first

**Provisional Diagnosis:**

- ☐ Sleep Apnea
- ☐ PLMS / RLS
- ☐ Narcolepsy**
- ☐ Parasomnia
- ☐ Insomnia++
- ☐ Other (specify) _____

**Symptoms leading to referral:**

- ☐ snoring
- ☐ snoring with apnea
- ☐ frequent awakenings
- ☐ restless legs during daytime
- ☐ repetitive movement during sleep
- ☐ fatigue
- ☐ somnolence
- ☐ unrefreshing sleep
- ☐ abnormal behavior during sleep
- ☐ difficulty getting to sleep
- ☐ difficulty staying asleep
- ☐ other (specify) _____

**Services Requested:**

- ☐ Diagnostic Sleep Study & Consult (if Sleep Study Abnormal)
- ☐ Repeat Diagnostic Sleep Study & Consult (if Sleep Study Abnormal)
- ☐ Sleep Study only
- ☐ Consult only
- ☐ CPAP Study
- ☐ Split-Night Study
- ☐ Sleep Study + MSLT**

**++ Insomnia Symptoms will result in a consult only**

**** Narcolepsy Symptoms will result in a consult first, prior to sleep study**

**Current Medications and Treatment Levels:**

_____

_____

_____

_____

on O2 @ _____ l/min

on CPAP @ _____ cm H2O

on BiLevel @ _____/_____ cm H2O

For Sleep Lab Use Only

- ☐ PSG
- ☐ CPAP Titration starting @ _____ cm H2O
- ☐ CPAP Reassess starting @ _____ cm H2O
- ☐ Split study - start CPAP if AHI = _____/hr
- ☐ BiLevel starting @ _____/_____ cm H2O

Appointment Date: _____

- ☐ TcpCO2 monitoring
- ☐ MSLT or MWT

Further instructions: _____

_____

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