Head Office: (905) 338-3331 www.PEAKsleep.ca

PATIENT:	
Address:	
Phone (Home):	
Phone (Cell):	
Email:	
Date of Birth:	Male □ Female□
Health Card #:	VC:

SLEEP STUDY REQUISITION

LOCATION:	**URGENCY:** Elective □ Semi-Urgent □ Urgent□
TEST REQUESTED: □ Diagnostic Sleep Study ONLY □ Diagnostic Sleep Study followed by CONSULT □ Consultation (tests as needed) □ CPAP/BiPAP Study (consult first as per OHIP)	**Previous Sleep Study:** Has the Patient had a Previous Sleep Study elsewhere? □ Yes _________ (year) □ No *If **YES**, RESULTS MUST BE ATTACHED*

PATIENT COMPLAINTS/SYMPTOMS:		**PROVISIONAL DIAGNOSIS:**
( ) difficulty falling asleep	( ) snoring	( ) Sleep Apnea
( ) frequent awakenings	( ) apnea	( ) PLM / Restless Legs
( ) unrefreshing sleep	( ) repetitive movement in sleep	( ) Narcolepsy/Hypersomnolence
( ) daytime somnolence/fatigue	( ) restless legs, day/evening	( ) Chronic Insomnia
( ) recurrent headaches	( ) parasomnia, abnormal behaviour in sleep	( ) Other___________________
( ) irresistible urge to sleep	( ) Other _______________________________	

MEDICAL HISTORY:		**CURRENT MEDICATIONS:**
□ Hypertension	□ Depression	___________________________________
□ Heart Disease	□ CNS	___________________________________
□ Asthma or COPD	□ Metabolic	___________________________________
□ Airway Surgery	□ Other: ___________________	___________________________________
		___________________________________

CURRENTLY ON:	**ALLERGIES:**	**OFFICE USE ONLY:**
Oxygen: ______________________ LPM CPAP/BiPAP: _________________ cmH_2O **SPECIAL NEEDS:** □ Language Barrier □ requires attendant – parent/other □ ambulation restricted – wheelchair □ other ______________________________		**Book:** ______________________________ **Medical Director:** ______________________________

Referring Physician: ____ **Address:** ______________________________
(please print)

Physician Signature: ____ **Phone:** ________________________________
(required)

Physician Number (billing): ___________________________________ **Fax:** __________________________________
(required)

Date: ____

Mini Satisfaction Survey - Indicate on the scale your level of satisfaction and/or make a comment:

Unsatisfied____Very satisfied