



www.accqsleeplabs.com

- K-W Fax: 519-745-7174
- Paris Fax: 519-442-7983
- Owen Sound: 519-371-5736

For Lab Use only:

- PSG:
- CPAP / Re-tx / BiPAP / VPAP:
- MSLT / MWT:
- Clinic Follow up:
- Other:

REQUEST FOR SLEEP STUDY

REQUESTING HEALTHCARE PROFESSIONAL TO COMPLETE The information you provide is vital to the selection of the correct sleep study for your patient. PLEASE PRINT CLEARLY	
Patient Name:	Phone: Work:
Address:	Cell: Email:
City: Postal code:	Pertinent history, physical findings and investigation results:
Health Card: Date of birth:	Height: _____ Weight: _____ BMI: _____ RESP
Requesting healthcare professional: _____ Signature: _____ OHIP billing: # _____ Family physician: _____ Referring healthcare professional: _____	CVS CNS METABOLIC AIRWAY SURGERY PRE-SURGICAL ASSESMENT YES NO
Symptoms leading to referral: <input type="checkbox"/> snoring <input type="checkbox"/> difficulty staying asleep <input type="checkbox"/> snoring with apnea <input type="checkbox"/> frequent awakenings <input type="checkbox"/> somnolence <input type="checkbox"/> daytime restless legs <input type="checkbox"/> unrefreshing sleep <input type="checkbox"/> repetitive movement during sleep <input type="checkbox"/> fatigue <input type="checkbox"/> abnormal behaviour during sleep <input type="checkbox"/> difficulty getting to sleep <input type="checkbox"/> other(specify) _____	Provisional diagnosis: <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Narcolepsy <input type="checkbox"/> REM Sleep Disorder <input type="checkbox"/> Nocturnal Myoclonus <input type="checkbox"/> Other(specify) _____
COMMENTS:	Services Requested: <input type="checkbox"/> Sleep Study <input type="checkbox"/> CPAP Study <input type="checkbox"/> Split-Night Study <input type="checkbox"/> PSG+MSLT <input type="checkbox"/> BiPAP Study <input type="checkbox"/> Consultation
Current Medications (may effect sleep quality):	NOTE: Booking Urgency (specify): _____ Date of Request: _____
On O ₂ _____ L/min CPAP _____ cm H ₂ O BIPAP _____ cm H ₂ O	NOTE: <input type="checkbox"/> The patient should be able to care for self during time in the Sleep Lab. <input type="checkbox"/> Please specify any special care needs.
FOR SLEEP LABORATORY USE ONLY	
Date of study _____ File # _____	
Type of study <input type="checkbox"/> Full Clinical <input type="checkbox"/> Full Clinical with CPAP/BIPAP <input type="checkbox"/> MSLT <input type="checkbox"/> Resp. with CPAP/BIPAP <input type="checkbox"/> TPCO2 <input type="checkbox"/> O ₂ ___ L/min <input type="checkbox"/> Other (specify) _____	
Medications <input type="checkbox"/> Continue <input type="checkbox"/> Stop	
Reporting Physician _____ Date _____	
Follow-up Appointment: Physician _____ Clinic Date/Location _____	
Prescription <input type="checkbox"/> Yes <input type="checkbox"/> No Specify _____	

