www.accqsleeplabs.com

☐ Paris Fax: 519-442-7983

☐ Owen Sound: 519-371-5736

For Lab Use only:

- ☐ **PSG:**
- ☐ **CPAP / Re-Tx / BiLevel / ASV:**
- ☐ **PSG/CPAP Split Night:**
- ☐ **CPAP/BiLevel Split Night:**
- ☐ **MSLT / MWT:**

Clinic Follow up:

Scoring Urgency: ASAP/Semi-Urgent/ weeks

REQUEST FOR SLEEP STUDY/CONSULT

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 *(MUST COMPLETE SECTIONS I, II, III, IV & V)*

SECTION I - Demographics

Patient Name:

Phone: **Work:**

Address:

Cell: **Email:**

City: **Postal code:**

Health Card: **Date of birth:**

Pertinent history, physical findings and investigation results:

Height:_____ Weight:_____ BMI:_____

RESP

CVS

CNS

METABOLIC

AIRWAY SURGERY

PRE-SURGICAL ASSESMENT YES NO

SECTION II – Heath Care Provider

Requesting healthcare professional: _____

Signature:_____ **OHIP billing: #**_____

Family physician: _____

Referring healthcare professional:_____

SECTION III – Symptoms leading to referral:

- ☐ Snoring
- ☐ Snoring with apnea
- ☐ Somnolence
- ☐ Unrefreshing sleep
- ☐ Fatigue
- ☐ Difficulty getting to sleep
- ☐ Difficulty staying asleep
- ☐ Frequent awakenings
- ☐ Daytime restless legs
- ☐ Repetitive movement during sleep
- ☐ Abnormal behaviour during sleep
- ☐ Other(specify)_____

SECTION IV – Provisional Diagnosis:

- ☐ Sleep Apnea
- ☐ UARS
- ☐ Narcolepsy
- ☐ Restless Leg Syndrome/Periodic Limb Movement Disorder
- ☐ Other(specify)_____

COMMENTS:

SECTION V - Services Requested:

☐Sleep Study ☐Consultation ☐BIPAP Study
☐CPAP Study ☐Split-Night Study ☐PSG + MSLT
☐Sleep Study & Consultation

Current Medications (may affect sleep quality)**:**

NOTE:
Booking Urgency (specify):_____
Date of Request:_____

On O_2 _____ L/min

CPAP _____ cm H_2O

BIPAP _____ cm H_2O

NOTE:

☐The patient should be able to care for self during time in the Sleep Lab.

☐Please specify any special care needs.

FOR SLEEP LABORATORY USE ONLY

Provisional diagnosis:

- ☐ OSA ☐ UARS
- ☐ Central/Mixed Sleep Apnea
- ☐ Narcolepsy
- ☐ REM Sleep Behaviour Disorder
- ☐ RLS/PLMD
- ☐ Other_____

COMMENTS:

- ☐ Currently on APAP trial
- ☐ Full-face mask to be used
- ☐ ETCO2 Monitoring
- ☐ Seizure/RBD montage
- ☐ Fall risk
- ☐ Other_____

On O_2 _____ L/min

CPAP _____ cm H_2O

BIPAP _____ / _____ cm H_2O

Rx: _____

Signature: _____