



www.accsleeplabs.com

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# REQUEST FOR SLEEP STUDY/CONSULT

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**

### 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: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

Postal code: \_\_\_\_\_

Health Card: \_\_\_\_\_

Date of birth: \_\_\_\_\_

#### SECTION II - Health Care Provider

Requesting healthcare professional: \_\_\_\_\_

Signature: \_\_\_\_\_ OHIP billing: # \_\_\_\_\_

Family physician: \_\_\_\_\_

Referring healthcare professional: \_\_\_\_\_

Phone: \_\_\_\_\_

Work: \_\_\_\_\_

Cell: \_\_\_\_\_

Email: \_\_\_\_\_

Pertinent history, physical findings and investigation results:

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_  
RESP \_\_\_\_\_

CVS \_\_\_\_\_

CNS \_\_\_\_\_

METABOLIC \_\_\_\_\_

AIRWAY SURGERY \_\_\_\_\_

PRE-SURGICAL ASSESMENT YES NO

#### 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<sub>2</sub> \_\_\_\_\_ L/min

CPAP \_\_\_\_\_ cm H<sub>2</sub>O

BIPAP \_\_\_\_\_ cm H<sub>2</sub>O

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
- ETCO<sub>2</sub> Monitoring
- Seizure/RBD montage
- Fall risk
- Other \_\_\_\_\_

On O<sub>2</sub> \_\_\_\_\_ L/min

CPAP \_\_\_\_\_ cm H<sub>2</sub>O

BIPAP \_\_\_\_\_ / \_\_\_\_\_ cm H<sub>2</sub>O

Rx: \_\_\_\_\_

Signature: \_\_\_\_\_