

REQUISITION FOR SLEEP STUDY OR CONSULTATION

Please complete in full and return by mail to
1145 Carling Avenue, Ottawa, Ontario K1Z 7K4, or by fax to 613.798.2980.

We will fax back the appointment date and time. It is the responsibility of the referring MD's office to inform the patient.
For more information about the Sleep Clinic, phone 613.722.6521 ext. 6248 or visit www.theroyal.ca/sleep

Referring Physician Information

Name	Address	Phone	Fax
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Patient Information

Languages English only French only Both

Surname	Given Names	Date of Birth (DD/MM/YY)	Marital Status	Sex M F
Address		Postal Code	Home Phone	
Employer			Work Phone	
Health Card No.		Version Code	Expiry Date	
Family Physician <input type="checkbox"/> same as above	Address		Phone No	

Reason for Referral (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Snoring/sleep apnea | <input type="checkbox"/> Daytime sleepiness/tiredness |
| <input type="checkbox"/> Insomnia/difficulty sleeping | <input type="checkbox"/> Restless legs/periodic leg movements |
| <input type="checkbox"/> Nocturnal behaviours (i.e. sleepwalking, sleep talking, confusional arousals) | |

Requests (check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Overnight sleep study | <input type="checkbox"/> Overnight sleep study with CPAP/BIPAP |
| <input type="checkbox"/> Multiple Sleep Latency Test (measures daytime sleepiness) | <input type="checkbox"/> Consultation by a Sleep Specialist |
| <input type="checkbox"/> Maintenance of Wakefulness Test (measures ability to stay awake) | |

Clinical Information

Symptoms, diagnoses and/or medications _____

Previous sleep study No Yes (If Yes, please attach copy)

Special Needs (e.g. wheelchair, etc.) _____

Physician signature _____ Date _____