The Le Royal
Mental Health - Care & Research
Santé mentale - Soins et recherche

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REQUISITION FOR SLEEP STUDIES | CONSULTATION

Please note: Incomplete referrals will be returned to the referring office.

REFERRING PHYSICIAN INFORMATION

Name: _____ Phone: _____

Address: _____ Fax: _____

PLEASE COMPLETE IN FULL

Patient Languages: ❑ English ❑ French ❑ Both

Surname: _____ Given Name(s): _____ Date of Birth: _____ (MM/DD/YY) Sex ❑ M ❑ F

Address: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

OHIP #.: _____ Version Code: _____ Province: _____
(non-OHIP patients require prior approval and pre-payment. Contact the sleep clinic)

Family Physician: _____ Address: _____ Phone No.: _____

PLEASE NOTE: ALL PATIENTS WILL HAVE AN INITIAL CONSULTATION APPOINTMENT PRIOR TO ANY TESTING

PLEASE PROVIDE REASON(S) FOR REFERRAL

❑ Snoring/Sleep Apnea ❑ Nocturnal behaviours *(i.e. sleepwalking)* ❑ CPAP reassessment
❑ Daytime sleepiness/Tiredness ❑ Insomnia/Difficulty sleeping ❑ Restless legs/Periodic leg movements

Describe sleep problem(s): _____

MEDICATONS: Please provide a complete list of current medications

CLINICAL HISTORY

Does the patient have any history of mental health issues? ❑ No ❑ Yes

Describe mental health history and any other relevant clinical diagnoses. _____

Please indicate any special needs:

Fall risk *(including cataplexy)*? ❑ No ❑ Yes *If yes, please describe:* _____

Has this patient had a previous sleep study? ❑ No ❑ Yes *If yes, please attach copy and/or complete information below.*

When? _____ Where? _____

Physician Signature _____ Physician Billing # (not CPSO #) _____ Date _____

WE WILL CONTACT THE PATIENT TO SET UP THE APPOINTMENT.