THE / LE ROYAL

Requisition for Sleep Studies | Consultation

PLEASE NOTE: Incomplete referrals will be returned to the referring office. | Non-OHIP patients require prior approval and pre-payment. Contact us. | All patients will have an initial consultation appointment prior to any testing. We will contact the patient to set up the appointment.

PATIENT INFORMATION (PLEASE COMPLETE IN FULL)

Last name: _____ First name: _____

Preferred name: _____

Date of birth: _____ (DD/MM/YYYY) Sex: ☐ Male ☐ Female Preferred pronouns: _____

Language(s) spoken: ☐ English ☐ French ☐ Both

Mailing address: _____

Home phone: _____ Work phone: _____ Mobile phone: _____

Email: _____

Health card number: _____ Version code _____ Province: _____

Family Physician: _____ Address: _____

Phone number: _____ Email: _____

Reasons for referral

☐ Snoring/Sleep apnea ☐ Nocturnal behaviours (e.g., sleepwalking) ☐ CPAP reassessment

☐ Daytime sleepiness/Tiredness ☐ Insomnia ☐ Restless legs/Periodic leg movements

Describe sleep problems: _____

Current medications (Please provide a complete list):

_____

_____

Clinical history

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

If yes, describe mental health history and any other relevant clinical diagnoses.

_____

Special needs

Fall risk (including cataplexy)? ☐ No ☐ Yes If yes, please describe:

Previous sleep study? ☐ No ☐ Yes If yes, please attach information unless completed at The Royal.

When: _____ Where: _____

REFERRING PHYSICIAN INFORMATION

Name: _____ Telephone: _____

Address: _____ Fax: _____

Physician Billing # (not CPSO #): _____

Physician Signature: _____ Date: _____ (DD/MM/YYYY)