Canadian Central Medical Referral Inc.

Integrated Medical Services Network

SERVING TORONTO AND THE GTA

LONDON KITCHENER HAMILTON MILTON OAKVILLE MISSISSAUGA BRAMPTON BARRIE NORTH YORK TORONTO RICHMOND HILL SCARBOROUGH MARKHAM DURHAM PICKERING AJAX WHITBY OSHAWA LINDSAY PETERBOROUGH COBOURG

SLEEP STUDY REQUISITION

Please fill in all information and email or fax to our office. Patients will be contacted directly.

E-mail: referrals@medreferral.ca Toll Free Fax: 1-855-566-8498 Toll Free Phone: 1-855-434-7373

1. Patient Information

Last: _____

First: _____

D.O.B: _____ ☐ Male ☐ Female

Health Card No: _____ VC: _____

Address: _____

_____ Postal Code: _____

Phone (H): (_____)_____ (C): (_____)_____

E-mail: _____

2. Request For

☐ Routine ☐ Urgent

☐ Sleep Study and Consultation

☐ Sleep Study Only

☐ Consultation Only

IMPORTANT: Has the patient ever had a sleep study at any time in the past?

☐ No ☐ Yes If yes, please specify the

Last Study Date: _____

Location: _____

Clinical Information

3. Reason For Referral

☐ Snoring ☐ Insomnia

☐ Suspected OSA ☐ Restless Legs

☐ Excessive Daytime Sleepiness

☐ Narcolepsy (Requires daytime test)

☐ Abnormal Sleep Behaviour (Sleep walking/talking)

☐ Other:

4. Relevant Medical History

Is the patient on

☐ CPAP ☐ APAP ☐ BiLEVEL ?

☐ No ☐ Yes: _____ cmH2O

Is patient on oxygen?

☐ No ☐ Yes: _____ lpm

☐ At Night Only ☐ Day and Night

Other: _____

5. Referring Physician Information

Name: _____

OHIP Billing No: _____

Address: _____

Phone: (_____)_____Fax: (_____)_____

Copy To: _____

Signature: _____ Date: _____

6. Additional Comments and Medication

Medication to be withheld during study?

7. Special Needs:

☐ Language: _____ ☐ Care Giver or Parent Accompaniment

☐ Ambulation: _____ ☐ Care Assistance: _____

For Office Use Only

☐ PSG ☐ MSLT ☐ Triaged (Sleep Dr. Initials): _____ Date: _____

☐ PAP Titration ☐ MWT ☐ Urgent

☐ PAP Re-Titration ☐ Additional Equipment: S/S Date: _____ Consult Date:_____

☐ PAP (Starting): _____ cmH_2O: _____ Special Considerations:

☐ PAP (Fixed): _____ cmH_2O: _____

This requisition form can be taken to any licensed facility providing health care services including hospitals accepting community referrals and community surgical and diagnostic centres, such as those listed on the website: https://www.ontario.ca/page/community-surgical-and-diagnostic-centres

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