The Ottawa Hospital | L'Hôpital d'Ottawa

Chart No.

Last name

First Name DOB S

Address Postal Code

Phone no.
Home Work
Provincial Ins. No. Version Expiration (date)

SLEEP MEDICINE PROGRAM REQUISITION

Sleep study or consult: phone: 613-761-4636 fax: 613-761-5211
Civic Campus: 1053 Carling Ave., Ottawa, Ontario K1Y 4E9

PLEASE COMPLETE IN FULL

PRINT name of Referring Physician

Tel. no. Fax no.

Signature of Referring Physician

Who else should be sent a copy?

Physician Office Stamp

The following information is required for all sleep study requests

1 Has the patient previously had a sleep study? (Ontario only covers 1 initial test; if so, a pre-study consult is required).
If so, WHEN AND WHERE: _____

2 Is the patient's weight greater than 400 lbs/180 kg ❑ yes ❑ no

Appointment: Date: Time:

Please indicate level of request:

❑ Routine Protocol (to include sleep study, and if indicated by results MWT, MSLT or any therapeutic study) and/or a consultation

❑ Sleep Specialist consultation **ONLY** (no sleep study)-name of preferred sleep specialist, if any

❑ MSLT (Multiple Sleep Latency Test) ❑ MWT (Maintenance of Wakefulness Test)

Reason for referral (clinical history)

❑ Snoring (rule out sleep apnea) ❑ Insomnia ❑ CPAP or other specify: _____
❑ Daytime sleepiness/tiredness ❑ Restless legs (periodic leg movements) ❑ Nocturnal Behaviour (sleep walking, sleep talking)

Additional information:

Please list medications patient is curently on:

Please indicate if there are any special needs (eg.: ambulating, transferring, attendant care, interpreter)

FOR SLEEP CENTRE USE ONLY: (triage and special requests)

When checking off multiple requests, please indicate in numerical order the sequence of tests/clinic

❑ Routine ❑ Urgent ❑ PSG ❑ CPAP ❑ Other-Specify (Split, Bilevel, ASV etc...) _____
❑ MSLT ❑ MWT ❑ Clinic Only ❑ RTC (Return to clinic)

Special Instructions/Comments ($TCCO_2$, Supine vs Sides, etc.) | Note to interpreter

Français au verso