



KITCHENER SLEEP & SNORING INSTITUTE

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www.sleepsnore.ca

PATIENT:
Address: _____
Phone (Home): _____
Phone (Cell): _____
Email: _____
Date of Birth: _____ Male <input type="checkbox"/> Female <input type="checkbox"/>
Health Card #: _____ VC: _____

SLEEP STUDY REQUISITION

LOCATION: Kitchener	URGENCY: Elective <input type="checkbox"/> Semi-Urgent <input type="checkbox"/> Urgent <input type="checkbox"/>
TEST REQUESTED: <input type="checkbox"/> Diagnostic Sleep Study ONLY <input type="checkbox"/> Diagnostic Sleep Study followed by CONSULT <input type="checkbox"/> Consultation (tests as needed) <input type="checkbox"/> CPAP/BiPAP Study (consult first as per OHIP)	Previous Sleep Study: Has the Patient had a Previous Sleep Study elsewhere? <input type="checkbox"/> Yes _____ (year) <input type="checkbox"/> No <i>If YES, RESULTS MUST BE ATTACHED</i>

PATIENT COMPLAINTS/SYMPTOMS: <input type="checkbox"/> difficulty falling asleep <input type="checkbox"/> snoring <input type="checkbox"/> frequent awakenings <input type="checkbox"/> apnea <input type="checkbox"/> unrefreshing sleep <input type="checkbox"/> repetitive movement in sleep <input type="checkbox"/> daytime somnolence/fatigue <input type="checkbox"/> restless legs, day/evening <input type="checkbox"/> recurrent headaches <input type="checkbox"/> parasomnia, abnormal behaviour in sleep <input type="checkbox"/> irresistible urge to sleep <input type="checkbox"/> Other _____	PROVISIONAL DIAGNOSIS: <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> PLM / Restless Legs <input type="checkbox"/> Narcolepsy/Hypersomnolence <input type="checkbox"/> Chronic Insomnia <input type="checkbox"/> Other _____
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MEDICAL HISTORY: <input type="checkbox"/> Hypertension <input type="checkbox"/> Depression <input type="checkbox"/> Heart Disease <input type="checkbox"/> CNS <input type="checkbox"/> Asthma or COPD <input type="checkbox"/> Metabolic <input type="checkbox"/> Airway Surgery <input type="checkbox"/> Other: _____	CURRENT MEDICATIONS: _____ _____ _____ _____
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CURRENTLY ON: Oxygen: _____ LPM CPAP/BiPAP: _____ cmH ₂ O	ALLERGIES: _____ _____	OFFICE USE ONLY: Book: _____ Medical Director: _____
SPECIAL NEEDS: <input type="checkbox"/> Language Barrier <input type="checkbox"/> requires attendant – parent/other <input type="checkbox"/> ambulation restricted – wheelchair <input type="checkbox"/> other _____		

Referring Physician: _____ (please print)	Address: _____
Physician Signature: _____ (required)	Phone: _____
Physician Number (billing): _____ (required)	Fax: _____
Date: _____	

Mini Satisfaction Survey - Indicate on the scale your level of satisfaction and/or make a comment:

Unsatisfied _____ Very satisfied

(Longer version of survey available on our website - www.sleepsnore.ca) Revised January 2018