CAMBRIDGE SLEEP & SNORING INSTITUTE
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PATIENT:	
Address:	
Phone (Home):	
Phone (Cell):	
Email:	
Date of Birth:	Male □ Female□
Health Card #:	VC:

SLEEP STUDY REQUISITION

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

PATIENT COMPLAINTS/SYMPTOMS:		**PROVISIONAL DIAGNOSIS:**
( ) difficulty falling asleep	( ) snoring	( ) Sleep Apnea
( ) frequent awakenings	( ) apnea	( ) PLM / Restless Legs
( ) unrefreshing sleep	( ) repetitive movement in sleep	( ) Narcolepsy/Hypersomnolence
( ) daytime somnolence/fatigue	( ) restless legs, day/evening	( ) Chronic Insomnia
( ) recurrent headaches	( ) parasomnia, abnormal behaviour in sleep	( ) Other_____
( ) irresistible urge to sleep	( ) Other _____	

MEDICAL HISTORY:		**CURRENT MEDICATIONS:**
□ Hypertension	□ Depresssion	_____
□ Heart Disease	□ CNS	_____
□ Asthma or COPD	□ Metabolic	_____
□ Airway Surgery	□ Other: _____	_____
		_____

CURRENTLY ON: Oxygen: _____ LPM CPAP/BiPAP: _____ cmH_2O **SPECIAL NEEDS:** □ Language Barrier □ requires attendant – parent/other □ ambulation restricted – wheelchair □ other _____	**ALLERGIES:**	**OFFICE USE ONLY:** **Book:** _____ **Medical Director:** _____

Referring Physician: _____ **Address:** _____
(please print)

Physician Signature: _____ **Phone:** _____
(required)

Physician Number (billing): _____ **Fax:** _____
(required)

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