SLEEP DISORDER ASSESSMENT REQUISITION FORM

INTERNATIONAL SLEEP CLINIC
West Parry Sound Health Centre
6 Albert Street
Parry Sound, ON P2A 3A4
Tel.#: Booking/Information (705)746-4540 Ext. 3306
Fax #: (705)773-4087

Patient Name: _____ **DOB** / / M F
DD/MM/YYYY ***Gender***

Address: _____

Tel.#: :*Home* ( ) ***Work*** ( )

Date : _____
DD/MM/YYYY

Health Card #: _____ **Version Code:** _____

☐**Sleep Study, consultation and management as required** ☐**Neuropsychiatric Evaluation and sleep study as required**
☐**Consultation, if required sleep study and management** ☐**Sleep study only (for other sleep medicine trained physician)**
☐ **Medicolegal issue/concern Evaluation, sleep study as required**

Previous Sleep Study: ☐ **Yes** ☐**No** **if yes, sleep study Date:_____**

ATTENTION TO:

☐ Dr. C. Shapiro ☐ Dr. L. van Zyl
☐ Dr. C. Hollinger ☐ Dr. M. Bohra
☐ Dr. R. Mankoo ☐ Dr. A. Shahid

FAMILY PHYSICIAN:

Dr.
Address:

Tel. #: ( )

REFERRING PHYSICIAN:

Dr.

Physician # :_____

Address:

Tel. #: ( )

Signature: _____

OTHER PHYSICIANS TO RECEIVE RESULTS:

Dr.
Address:

Tel. #: ( )

REASON(S) FOR REFERRAL:

☐ Snoring ☐ Narcolepsy ☐ Treatment Follow-Up ☐ Obesity
☐ Sleep Apnea ☐ Parasomnia ☐ Circadian Rhythm Disorder ☐ Impotence
☐ Insomnia ☐ Nocturnal Seizure ☐ Mood Disorder ☐ Fragmented sleep
☐ Excessive Daytime Sleepiness ☐ Head injury ☐ Nocturnal Panic ☐ Tourette's
☐ Restless Legs Syndrome ☐ CPAP Titration ☐ Fibromyalgia ☐ Parkinson's
☐ Periodic Limb Movements ☐ CPAP Follow-Up ☐ Bruxism ☐ Neuromuscular Disease
☐ Rhythmic Movement Disorder ☐ Oral Appliance Titration/Assessment
☐ OTHER _____

Past Medical History:

Medications: ☐ **None**

☐ **Please check here if you would like another referral pad**

or Visit: www.sleepontario.com