SLEEP DISORDER ASSESSMENT REQUISITION FORM

SLEEP AND ALERTNESS CLINIC
790 Bay Street
Suite 800
P.O. Box 32
Toronto, ON M5G 1N8
Tel. #: (416) 837-8181 or (647) 479-2156
Fax #: (647) 427-4928

Date: _______ / ______ / ______

Patient Name: ____________________________
DOB: / / DD/MM/YYYY
Gender M F

Address: ____________________________

Tel. #: Home: ( ) Work/cell: ( )

Email: ____________________________

Health Card #: ____________________________ Version Code: ______

☐ Sleep Study, consultation and management as required
☐ Sleep Study only (for other sleep medicine trained physician)
☐ Consultation, if required sleep study and management

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

ATTENTION TO:
☐ Dr. C. Shapiro ☐ Dr. S. Ho ☐ Dr. R. Ng
☐ Dr. A. Ong ☐ Dr. J. Barbera ☐ Dr. V. Likhornik
☐ Dr. L. Van Zyl ☐ Dr. G. Hollinger ☐ Dr. G. Panjwani
☐ Dr. M. Alenazi ☐ Dr. R. Mankoo ☐ Dr. J. Gojer
☐ Dr. D. Zalai

FAMILY PHYSICIAN (if not referring physician):
Dr. Address:
Tel. #: ( )

OTHER PHYSICIANS TO RECEIVE RESULTS:
Dr. Address:
Tel. #: ( )

REFERRING PHYSICIAN:
Dr. ____________________________
Physician/Billing # ____________________________
Address: ____________________________
Tel. #: ( )
Signature: ____________________________

REASON FOR REFERRAL:
☐ Snoring ☐ Narcolepsy ☐ Treatment Follow-Up ☐ Obesity
☐ Sleep Apnea ☐ Parasomnia ☐ Circadian Rhythm Disorder ☐ Impotence
☐ Insomnia ☐ Nocturnal Seizure ☐ Mood Disorder ☐ Head injury
☐ Excessive Daytime Sleepiness ☐ CPAP Titration ☐ Nocturnal Panic ☐ Tourette’s
☐ Restless Legs Syndrome ☐ CPAP Follow-Up ☐ Fibromyalgia ☐ Parkinson’s
☐ Periodic Limb Movements ☐ Oral Appliance Assessment ☐ Rhythmic Movement Disorder ☐ Neuromuscular Disease
☐ Maxillofacial Assessment ☐ ENT Assessment ☐ Psychological Sleep Management
☐ OTHER ____________________________

Past Medical History: ____________________________

Medications: ☐ None