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: _____
DD/MM/YYYY

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

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. A. Ong
- ☐ Dr. L. Van Zyl
- ☐ Dr. M. Alenazi
- ☐ Dr. D. Zalai
- ☐ Dr. S. Ho
- ☐ Dr. J. Barbera
- ☐ Dr. G. Hollinger
- ☐ Dr. R. Mankoo
- ☐ Dr. R. Ng
- ☐ Dr. V. Likwornik
- ☐ Dr. G. Panjwani
- ☐ Dr. J. Gojer

FAMILY PHYSICIAN (if not referring physician)**:**

Dr.
Address:

Tel. #: ( )

REFERRING PHYSICIAN:

Dr.

Physician/Billing # _____

Address:

Tel. #: ( )

Signature: _____

OTHER PHYSICIANS TO RECEIVE RESULTS:

Dr.
Address:

Tel. #: ( )

REASON FOR REFERRAL:

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

☐ OTHER _____

Past Medical History:

Medications: ☐ None