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

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

Address: _____

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

Email: _____

Date: _____ *DD/MM/YYYY*

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

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

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. A. Margaliot
☐ Dr. L. Van Zyl	☐ Dr. G. Hollinger	☐ Dr. G. Panjwani
☐ Dr. M. Alenazi	☐ Dr. R. Mankoo	☐ Dr. J. Gojer

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

Dr. _____
Address: _____
_____
Tel. #: _____ Ext: _____

REFERRING PHYSICIAN:

Dr. _____
Physician/Billing # _____
Address:
Tel. #: ( ) Ext: _____
Signature: _____

OTHER PHYSICIANS TO RECEIVE RESULTS:

Dr. _____
Address: _____
_____
Tel. #: _____ Ext: _____

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
☐ Headache	☐ CPAP Follow-Up	☐ Fibromyalgia	☐ Parkinson's
☐ Restless Legs Syndrome	☐ Oral Appliance Assessment	☐ Rhythmic Movement Disorder	☐ Neuromuscular Disease
☐ Periodic Limb Movements	☐ Maxillofacial Assessment	☐ Psychological Sleep Management	

☐ OTHER _____

Past Medical History:

Medications: ☐ None

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