



Tri-Hospital Sleep Laboratory West

Telephone: (905) 566-1010
Fax: (905) 566-0440

COOKSVILLE COLONNADE
3024 HURONTARIO STREET, SUITE 208, MISSISSAUGA, ONTARIO L5B 4M4

Sleep Study Requisition

DATE _____

Patient will be notified directly. Please fill in all information accordingly.

LAST NAME _____ FIRST NAME _____

DATE OF BIRTH _____ MALE FEMALE

ADDRESS _____

POSTAL CODE _____

PHONE (HOME) () _____ PHONE (WORK) () _____

HEALTH CARD # _____ E-MAIL _____

Clinical Information

REASON FOR REFERRAL URGENT ELECTIVE

SLEEP STUDY AND CONSULTATION SLEEP STUDY ONLY CONSULT ONLY

CLINICAL PROFILE

- SNORING/SLEEP APNEA
- DAYTIME SLEEPINESS/FATIGUE
- MORNING HEADACHES
- NON-RESTORATIVE SLEEP
- COPD/ASTHMA
- HYPERTENSION/CHF
- CPAP REASSESSMENT
- MOOD DISORDER
- INSOMNIA
- SLEEP WALKING/NARCOLEPSY
- FIBROMYALGIA/CFS
- RESTLESS LEGS/
PERIODIC LIMB MOVEMENT
- NOCTURNAL SEIZURE

FOR OFFICE USE ONLY

- NPSG
- CPAP TITRATION/FOLLOW UP
@ _____ cm
- BIPAP _____ / _____
- SERVO-VENT _____ / _____ / _____
- MSLT/MWT ETCO₂
- TRIAGED _____

RELEVANT MEDICAL HISTORY _____

MEDICATIONS _____

ALLERGIES _____

PREVIOUS STUDY? YES NO DATE: _____

Referring Physician

NAME _____ SIGNATURE _____

OHIP BILLING # _____

ADDRESS _____

POSTAL CODE _____

TELEPHONE () _____ FAX () _____ E-MAIL _____

COPY TO

ADDRESS _____

POSTAL CODE _____

TELEPHONE () _____ FAX () _____ E-MAIL _____

SLEEP STUDY APPT. _____ FOLLOW-UP APPT. _____

Dr. M. R. Goolam Hussain, MD, CCFP, FCFP, DABSM, FAASM – Medical Director

