Tri-Hospital Sleep Laboratory West

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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 ☐ URGENT
☐ CPAP TITRATION/FOLLOW UP @ _____ cm
☐ BIPAP_____ /_____
☐ SERVO-VENT _____ /_____ /_____
☐ MSLT/MWT ☐ $ETCO_2$
☐ TRIAGED_____

RELEVANT MEDICAL HISTORY

MEDICATIONS

ALLERGIES

PREVIOUS STUDY? ☐ YES ☐ NO DATE AND LOCATION:

SPECIAL NEEDS

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