THE SLEEP DISORDERS CLINIC

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POST HOSPITALIZATION DIAGNOSTIC SLEEP STUDY AND CPAP TREATMENT REQUISITION

*IMPORTANT: DOCTORS: USE THIS FORM FOR **IN HOSPITAL PATIENTS ON CPAP/ BIPAP ONLY.***

PATIENT'S NAME:_____DATE OF BIRTH:_____
(DD/MM/YYYY)

ADDRESS:_____

HEALTH CARD NUMBER:_____VERSION CODE:_____

PHONE NUMBER:_____AFTER HOURS/ CELL:_____

PATIENTõS EMAIL ADDRESS: _____

REFERRING PHYSICIAN: _____PHYSICIANõS BILLING NUMBER:_____

FAMILY DOCTOR (if different to referring doctor):_____

REFERRING PHYSICIANõS SIGNATURE:_____

ESTIMATED DATE OF DISCHARGE: _____/_____/_____

DISCHARGE DIAGNOSIS:

PATIENT IS ON ☐ **CPAP** CURRENT PRESSURE ☐ **APAP** CURRENT PRESSURE: ☐ **BIPAP** IPAP EPAP
DATE OF INITIATION OF THERAPY:
NOCTURNAL OXIMETRY: ☐ YES ☐ NO ☐ ATTACHED
PATIENT HAS EQUIPMENT FOR HOME USE: ☐ YES ☐ NO VENDOR:

Patient should be able to care for self in sleep lab. ☐ Problems with mobility ☐ Incontinence ☐ Urinary ☐ Fecal ☐ Communication (Hearing impaired, language, etc) ☐ Developmental/Psychological Disorder ☐ History of Violence ☐ History of Seizure Disorder ☐ Infectious Disease ☐ TB ☐ MRSA ☐ VRE	**Referral site**: ☐ General Hospital: Unit: ☐ MUMC: Unit: ☐ Henderson: Unit: ☐ Juravinski Hospital: Unit: ☐ **Enter phone number:**_____ Resident in charge:_____
SYMPTOMS LEADING TO REFERRAL: ☐ Desaturations in hospital: lowest value: ____% ☐ Witnessed apnea ☐ Significantly overweight (BMI >30) ☐ Height: _____Weight:_____ ☐ Excessive daytime sleepiness ☐ Unrefreshing sleep	☐ Frequent awakenings ☐ Difficulty initiating or maintaining sleep ☐ Restless legs ☐ Unusual movement during sleep ☐ Abnormal behaviour during sleep ☐ Other (specify)_____ ☐ Oxygen _____l/min
WORKING DIAGNOSIS: ☐ Sleep apnea	☐ Other (specify)_____
OTHER MEDICAL DIAGNOSES: (Specify) ☐ Cardiac History_____ ☐ DM	☐ Hypertension ☐ Medically Stable ☐ Other (specify)_____