THE SLEEP DISORDERS CLINIC

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PRE-OPERATIVE DIAGNOSTIC PSG AND CPAP TREATMENT REQUISITION

*IMPORTANT: ANESTHETISTS AND SURGEONS: USE THIS FORM FOR **PRE-OP PATIENTS ONLY.***

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

ADDRESS:_____

HEALTH CARD NUMBER:_____VERSION CODE:_____

PHONE NUMBER:_____AFTER HOURS/ CELL:_____

PATIENT'S EMAIL ADDRESS: _____

REFERRING PHYSICIAN'S NAME: (PLEASE PRINT)_____

PHYSICIAN'S SIGNATURE: _____PHYSICIAN'S BILLING NUMBER:_____

FAMILY DOCTOR (if different to referring doctor):_____

SURGICAL PROCEDURE:_____

DATE OF SURGERY:_____/_____/_____NAME OF SURGEON:_____

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**: Enter fax number to receive sleep study report ☐General Hospital FAX: (905) 527-9757 ☐MUMC FAX: (905) 521-4952 ☐Henderson FAX: (905) 575-2673 ☐**Other: enter phone number:_____** Additional comments:_____
SYMPTOMS LEADING TO REFERRAL: ☐Snoring ☐Snoring with 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)_____
☐Patient has had a sleep study within past five years. ☐Patient has been treated with CPAP in the past. Reports within past five years must be provided.	☐CPAP _____cm H2O ☐BIPAP IPAP_____cm H2O EPAP _____cm H2O