ST JOSEPH'S
HEALTH CENTRE TORONTO

REQUISITION FOR SLEEP STUDY

St. Joseph's Health Centre
East Wing, Room 1E-108
30 The Queensway, Toronto ON

Phone Line: 416-530-4599
Fax Line: 416-530-6702

Name: ______________________
Male ☐ Female ☐
MRN : ______________________
DOB: ______________________
Address: ______________________
____
Telephone: ______________________
OHIP #: ______________________

INCOMPLETE FORMS WILL BE RETURNED AND NOT PROCESSED

☐ Outpatient ☐ ACC ☐ URGENT (please provide clinical information)

IMPORTANT: Has a sleep study been done previously at St. Joseph's Health Centre or any other sleep laboratory?
☐ No ☐ Yes*: list dates of last 2 studies ______________________ (please attach results if available)

REFERRAL REQUEST
☐ Sleep study only
☐ Sleep study and consultation (if abnormal)
☐ Consultation only

REASON FOR REFERRAL
☐ Obstructive sleep apnea/snoring
☐ Excessive daytime sleepiness
☐ Restless legs*
☐ Insomnia*
☐ Other/co-morbidities:

*These patients will be seen in consultation prior to testing

OTHER INFORMATION
Is patient on CPAP/BiPAP? ☐ Yes: ______ cmH2O Is patient on oxygen? ☐ Yes: ___ L/min
Is the patient's weight >400 lbs/180 kg? ☐ Yes
Other special needs? ______________________

ADDITIONAL INFORMATION
Does Patient Consent to Appointment Information Being Disclosed in a Telephone Message? ☐ Yes ☐ No
Is Patient Able to Come in on Short Notice? ☐ Yes ☐ No
Contact/telephone number: ______________________

LAB USE ONLY
☐ Diagnostic Polysomnogram
☐ Bi-level titration – start at __________
☐ CPAP titration – start at __________
☐ Split study – start CPAP at __________
☐ Additional instructions:
☐ Study date

REQUESTING PHYSICIAN
Address:______________________City:______________________ Postal Code:______________________
Telephone Number:______________________Fax:______________________ CPSO #:______________________
Copy to: ______________________ MD (Physician's Printed Name)

DATE	SIGNATURE	PRINT NAME AND OHIP BILLING NUMBER
DD / Month / YYYY		

Form No. 74074 Dev. Feb26_2019