HOSPITAL ALLIANCE GROUP

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SLEEP LABORATORY REFERRAL FORM

PLEASE CHOOSE A LOCATION ❑ **Alliston** ❑ **Espanola** ❑ **Hawkesbury** ❑ **Lindsay** ❑ **Parry Sound** ❑ **Timmins** ❑ **Winchester**

SERVICES REQUESTED

☒ **Sleep Study, followed by consultation**
☐ **Consultation, followed by sleep studies**
☐ **Sleep Study only**
☐ **Consult only**

Has the patient had a previous sleep study? ❑ No ❑ Yes Date ________________

Patient Name ____ Sex ❑ M ❑ F
(PLEASE PRINT) (LAST) (FIRST)

OHIP # ______________________ | | | VERSION CODE ❑ Non-OHIP DOB (D/M/Y)____/____/__________

Address ____

Cell Number ( )______-________ **Home Number** ( )______-________ **Work Number** ( )______-________

Email ____

Emergency Contact ______________________ **Tel. Number** ( )______-________

Available on Short Notice? ❑ **Yes** ❑ **No**

Requesting Physician ______________________________ Billing Number ____________________

Address ____

Tel. Number ( )______-________ Fax Number ( )______-________

Family Physician ______________________ Fax Number ( )______-________

PATIENT COMPLAINT/INQUIRY

❑ Snoring
❑ Excessive Daytime Sleepiness (EDS)
❑ Insomnia
❑ Witnessed Apneas
❑ R/O Sleep Apnea
❑ Morning Headaches
❑ Restless Legs/Leg Cramps
❑ Fibromyalgia/Chronic Fatigue
❑ Obesity
❑ Other: ______________________

Medications/Allergies ____

Physician Signature ______________________________ Date ____________________

LAB USE ONLY

PROCEDURE

❑ Initial Diagnostic Sleep Study (PSG)
❑ Repeat PSG*
❑ PSG followed by MSLT* ❑ MWT*
❑ Seizure Montage*
❑ Parasomnia Montage*
***Consultation Required**

❑ CPAP
❑ CPAP F/U
❑ BPAP: Starting Pressure__________❑S ❑S/T
❑ BPAP F/U
❑ CO_2 Monitoring
❑ Oral Appliance Titration
❑ Positional Therapy

Special Instructions ____

Appointment Date & Time ____

Referring Physician ______________________ **Interpreting Physician** ______________________