WOODBINE • STEELES
SLEEP CLINIC

SUITE B103, 7155 WOODBINE AVE.
MARKHAM, L3R 1A3
TEL: 416-628-4010
FAX: 416-628-4009
www.wssleepclinic.com
info@wssleepclinic.com

STUDY REQUISITION FORM

Patient Information:

Patient's Name: _____ (Male / Female)
Last Name First Name

Address: _____

City: _____ Postal Code: _____

Home Phone: _____ Work/cell phone: _____

Date of Birth: _____(M)/_____(D)/_____(Y) Language: ( ) Mandarin/Cantonese ONLY

Health Card Number: _____ Version Code: _____

Clinical Information:

Relevant Medical Conditions: _____

_____

Medications: _____

Previous sleep test: ☐ YES – DATE: _____ ☐ NO
Allergies: ☐ YES _____ ☐ NO
On oxygen: ☐ YES _____ L/Min ☐ NO
On CPAP: ☐ YES _____ Cm H_2O ☐ NO

Sleep Study Requested:

☐ Sleep study only ☐ Consultation only ☐ Sleep study & consultation

Type of Study Requested:

☐ Diagnostic Sleep Study ☐ CPAP Titration ☐ MSLT (Multiple Sleep Latency Test + Overnight Study the night before)

Urgency: ☐ Elective ☐ Urgent (< 72 hours) ☐ Emergency (immediate)

Reason for Referral:

☐ Snoring / Suspected sleep apnea ☐ Chronic Insomnia ☐ Restless Leg
☐ Cardiovascular Risk Factors ☐ Abnormal Sleep Pattern ☐ Narcolepsy
☐ Excessive Daytime Sleepiness ☐ Others : _____

Referring Physician Information:

Referring Physician: _____ OHIP Billing #: _____
Phone Number: _____ Fax Number: _____
Address: _____ Signature & Date: _____

**** If you need to reschedule or cancel the study, please provide at least 48 hours notice or late cancellation fee may applied.**

OFFICE USE ONLY:

Appointment date: sleep study: _____ Consultation: _____

☐ Patient Informed Other: _____

Approved by: