OSHAWA DURHAM
SLEEP LABORATORY
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SLEEP STUDY REQUISITION

Patient's Last Name_____ First Name_____

Address _____City _____ Postal Code _____

Phone: Home _____Work _____ Mobile _____

Date of Birth (dd/mm/yyyy) _____Gender _____

Health Card No._____ VC_____ Expiry_____

List any special needs (language, ambulation, caregiver, relative/PS worker to stay) _____

_____

_____ FULL SLEEP STUDY ONLY
_____ FULL SLEEP STUDY WITH CONSULTATION AND TREATMENT - URGENT _____
_____ CONSULTATION ONLY
_____ REMOTELY CONTROLLED MANDIBULAR REPOSITIONER STUDY
_____ CPAP Titration: **FOR LAB USE:** Begin at: _____cm Initial CPAP _____cm Re-titration
_____ BPAP-S Titration: **FOR LAB USE:** Begin at ____/ _____cm Initial BPAP-S ___/___ cm Re-titration
_____ BPAP-ST Titration: **FOR LAB USE:** Begin at____/_____ cm _____Back up rate ___/ ___cm Re-titration
_____ Auto SV Titration: **FOR LAB USE:** Begin at PS min ____cm PS max ____ cm
EPAP min ____cm EPAP max ____ cm
_____ MULTIPLE SLEEP LATENCY TEST (MSLT)_ ___ MAINTENANCE OF WAKEFULNESS TEST (MWT)
_____ SPLIT STUDY **FOR LAB USE:** If RDI is > _____ then begin CPAP at _____cm

Relevant Clinical Sleep History (check **at least 3** and all that apply)
Snoring ___ Observed apnea during sleep _____ Excessive daytime sleepiness _____ Restless sleep_____
Irritability ____ Morning headaches _____ Leg movements during sleep _____ Teeth grinding_____
Memory Loss _____ Poor concentration _____ Frequent Urination at Night _____ Depression_____
IF A COMPARISON FULL SLEEP STUDY:
Details: Weight Loss____ Weight Gain _____ Oral Appliance ____ Meds _____
Post Surgery (Type): _____ Other _____
Pertinent Medical History
Hypertension ___ High cholesterol ___ Irregular heartbeat ____Diabetes Mellitus ___ COPD _____
Gastric Reflux ___ Crowded Airway ___ Sexual Dysfunction ___ Hypothyroidism ____
Fibromyalgia ___ Large neck size ___ BMI more than 35 _____ TMJ (pain, clicking, popping) _____
Current Medications:_____
_____
Please indicate any **meds to be withheld** during sleep study and reason: _____
Please indicate if patient is using **supplemental oxygen** and reason: _____
Additional information (if needed):
_____
_____

TO BE COMPLETED BY REFERRING PHYSICIAN

Date: _____Signature: _____ OHIP Registration No. _____ Please print physician's name: _____Address: _____

Please copy report to Dr. _____

_____Please send more Sleep Study Requisitions _____ Copies of previous sleep studies attached

For Lab use only: Additional orders (e.g Split study orders for BPAP, Auto SV, particular mask, RBD montage, Seizure montage)

_____
_____