St. Joseph's Healthcare Hamilton

Charlton Campus

Referring Physician Contact Information

SLEEP DISORDERS ASSESSMENT

PLEASE PRINT. Incomplete/illegible forms will be returned.

Fax complete form to: 905-521-6184

Date of Request: (yyyy/mm/dd)	**Booking Urgency:** ❑ **Routine** ❑ **Urgent** ❑ **Critical**	**Reason for Urgency:**

Check required appointments. Check one from EACH row:

❑ Physician Consultation and Sleep Study ❑ Physician Consultation ❑ Sleep Study Only

❑ First Available Sleep Specialist ❑ Other (specify) Dr._____

Required MOHLTC: Has patient had any previous sleep studies?: ❑ Yes ❑ No ❑ Unknown

Patient Name: LAST: _____ FIRST: _____ MIDDLE: _____

Address: _____ **City:** _____ **Postal Code:** _____

Phone (Home): _____ **(Mobile):** _____ **(Work):** _____

Date of Birth: YYYY: _____ MM: _____ DD: _____ **Age:** _____ **Sex:** ____ **Weight:** _____ **kg / lbs (Must)**

HCN: _____ **Version:** _____ **Unit Number:** _____

SPECIFY ANY SPECIAL NEEDS: Patient should be able to care for self during time in lab.

Mobility Problems: ❑ No ❑ Yes *specify:* _____

Language/Communication Problems: ❑ No ❑ Yes *specify:* _____

Other: *specify*:

Symptoms Leading to Referral:

❑ Snoring
❑ Snoring with apnea
❑ Somnolence
❑ Unrefreshing sleep
❑ Fatigue
❑ Difficulty getting to sleep
❑ Difficulty staying asleep
❑ Frequent awakenings
❑ Daytime restless legs
❑ Repetitive movement during sleep
❑ Abnormal behaviour during sleep
❑ Other: _____

Provisional Diagnosis:

❑ Sleep Apnea
❑ Narcolepsy
❑ REM Sleep Disorder
❑ Nocturnal Myoclonus
❑ Other: _____

Pertinent history, physical findings and investigation results:

RESP _____ CVS _____

CNS _____ Metabolic _____

Airway Surgery _____

Other:

Current Medications: (may affect sleep quality)

Comments:

❑ **On O_2** _____L/min

❑ **CPAP** _____cm H_2O

❑ **BIPAP**
IPAP _____cm H_2O
EPAP _____cm H_2O

Requesting Physician: × _____ **Specialty:** _____

Signature: × _____ **OHIP Billing #:** _____

Family Physician: _____ **Referring Physician:** _____

♦ FOR SLEEP LABORATORY USE ONLY ♦

Triage: ☐ Consult & Sleep Study ☐ Consult ☐ Sleep Study **Sleep Physician:** _____ **Date:** _____ **T/P** _____

Type of Study: ☐ Full Clinical ☐ Full Clinical with ☐ CPAP ☐ BIPAP Starting IPAP/ EPAP_____ Max IPAP _____ PS _____ ☐ ASV

☐ Split with CPAP ☐ Video ☐ $TPCO_2$ ☐ O_2_____L/min ☐ MSLT ☐ MWT

Medications: ☐ Continue ☐ Stop *(specify)* _____

Technologist Review: _____

Consult: Physician: _____ Date _____ (yyyy / mm / dd) Time:_____ (hh:mm) **Sleep Study:** Date: _____ (yyyy / mm / dd) Time:_____ (hh:mm)