SUBMIT FORM

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SLEEP DISORDER REQUEST FOR TESTING

REFERRING DOCTOR INFORMATION		
Name:		
Address:		
Fax:	Phone:	Email:

Patient Name : _____ Date of Birth: DD / MM / YYYY

Home Address/Postal Code : _____

Main Phone #: _____ Cell Phone #: _____ Alternative Phone #: _____

Sex: ☐ Male ☐ Female Weight: _____ Height: _____ BMI: _____ Neck Circ: _____

REFERRAL CAUSE	COMORBIDS
MAJOR CONCERN (Check One)	Hypertension (HTN) ☐ Yes ☐ No
☐ Snoring	Ischemic Heart Disease (IHD) ☐ Yes ☐ No
☐ Apnea	Congestive Heart Failure (CHF) ☐ Yes ☐ No
☐ Insomnia	Arrhythmia ☐ Yes ☐ No
☐ Parasomnia	Stroke ☐ Yes ☐ No
☐ Restless Leg Syndrome	Chronic Obstructive Pulmonary Disease (COPD) ☐ Yes ☐ No
☐ Hypersomnolence	
☐ Respiratory Failure	Chronic Respiratory Failure (CRF) ☐ Yes ☐ No
☐ Narcolepsy	Overnight WatchPAT 200 Testing
Previous Sleep Study Performed ☐ Yes* ☐ No	Follow up Overnight WatchPAT 200 Testing
*Please send copy of previous study	Repeat WatchPAT 200 Testing

Other relevant medical concerns:

PATIENT COMPLAINS OF - CHECK ALL THAT APPLY

☐ Snoring	☐ Daytime Sleepiness	☐ Hormore Abnormality
☐ Breathing Interruptions	☐ Poor memory and depression	☐ Depression
☐ Gasping and chocking sensation	☐ Wakes to go to the washroom	☐ Diabetes
☐ Awaken with a dry mouth	☐ Witnessed Apneas	☐ Morning headaches
☐ Fatigue upon awakening	☐ Night Sweats	

Does patient operate heavy/dangerous equipment/transport vehicles? ☐ Yes ☐ No

Would any physical assistance or family support be needed for an overnight study? ☐ Yes ☐ No

Details if Yes:

_____ Doctor's Signature

_____ Today's Date

Sleep Lab Chart Copy

PRIORITY STATUS FOR APPT SCHEDULING COMPLETED BY SLEEP DISORDER CENTRE PERSONNEL ONLY: ☐ **HIGH** ☐ **MODERATE** ☐ **MILD**