SLEEP DISORDER ASSESSMENT REQUISITION FORM

SLEEP AND ALERTNESS CLINIC
790 Bay Street
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P.O. Box 32
Toronto, ON M5G 1N8
Tel. #: (647) 479-2156
Fax #: (647) 427-4928

Date: ____________
DD/MM/YYYY

Patient Name: ____________ **DOB** / / *DD/MM/YYYY* M F ***Gender***

Address: ____________

Tel.#: ***Home:*** ( ) ***Work/cell:*** ( )

Email: ____________

Health Card #: ____________ **Version Code:** ____

ATTENTION TO:

- ☐ Dr. C. Shapiro
- ☐ Dr. A. Ong
- ☐ Dr. L. Van Zyl
- ☐ Dr. M. Alenazi
- ☐ Dr. D. Zalai
- ☐ Dr. S. Ho
- ☐ Dr. J. Barbera
- ☐ Dr. G. Hollinger
- ☐ Dr. R. Mankoo
- ☐ Dr. R. Ng
- ☐ Dr. V. Likwornik
- ☐ Dr. G. Panjwani
- ☐ Dr. J. Gojer

FAMILY PHYSICIAN (if not referring physician)**:**

Dr.
Address:
Tel. #: (**)**

REFERRING PHYSICIAN:

Address:
Dr.
Tel. #: (**)** **Physician # :**____________
Signature: ____________

OTHER PHYSICIANS TO RECEIVE RESULTS:

Dr.
Address:
Tel. #: (**)**

REASON FOR REFERRAL:

- ☐ Snoring
- ☐ Sleep Apnea
- ☐ Insomnia
- ☐ Excessive Daytime Sleepiness
- ☐ Restless Legs Syndrome
- ☐ Periodic Limb Movements
- ☐ Maxillofacial Assessment
- ☐ Narcolepsy
- ☐ Parasomnia
- ☐ Nocturnal Seizure
- ☐ CPAP Titration
- ☐ CPAP Follow-Up
- ☐ Oral Appliance Assessment
- ☐ ENT Assessment
- ☐ Treatment Follow-Up
- ☐ Circadian Rhythm Disorder
- ☐ Mood Disorder
- ☐ Nocturnal Panic
- ☐ Fibromyalgia
- ☐ Rhythmic Movement Disorder
- ☐ Psychological Sleep Management
- ☐ Obesity
- ☐ Impotence
- ☐ Head injury
- ☐ Tourette's
- ☐ Parkinson's
- ☐ Neuromuscular Disease

☐ OTHER ____________

Past Medical History:

Medications: ☐ None