Trillium Sleep Laboratory

Suite 405, 4190 Finch Ave East, Scarborough, Ont., M1S 4T7
Tel: 416-292-8292 Fax: 416-292-6733

Sleep Study Requisition

睡熊猫
Sleep Panda
Tel: 905 604 9191
Fax: 905 604 9393

No. _____

Patient Information:

Last Name : _____ First Name : _____

Date of Birth.: ____ / ____ / ____ (Day / Month / Year) ☐ Male ☐ Female

Address : _____

_____ Postal Code: _____

Phone No.: Home: (____) _____ Work: (____) _____

Family Physician: _____ Language: ☐ English ☐ Cantonese ☐ Mandarin

Health Card No. : ☐☐☐☐ – ☐☐☐ – ☐☐☐ Version Code ☐☐

Referral Request :

☐ Sleep Study ☐ CPAP Titration ☐ Consultation Only ☐ Sleep study & Consultation Required

Clinical Diagnosis : *Please indicate reason for study*

☐ Snoring ☐ Sleep Apnea ☐ Narcolepsy ☐ Insomnia ☐ Excessive Daytime Sleepiness

☐ Abnormal Sleep Behaviours ☐ Congestive Heart Failure ☐ Others _____

Clinical Information:

Past Medical History: _____

Medications : _____

ALLERGIES ☐ Yes _____ ☐ No

On oxygen : ☐ Yes _____ L / Min ☐ No

On CPAP : ☐ Yes _____ Cm H_2O ☐ No

Previous Sleep Study : Trillium Sleep Lab. ☐ Yes ☐ No If yes Date ____ / ____ / ____

Others ☐ Yes ☐ No If yes, please attach report.

Referring Physician: _____

Tel No.: _____ Fax No.: _____ Physician No.: _____

Signature _____ *Date* _____

* Please check: ☐ Interpertation of the study

☐ The full report (Interpertation and original data)

* **If unable to keep this appointment, please give at least 48 hours notice for cancellation.**

Office Use Only:

Appointment Date: Sleep Study _____ Consultation _____

Instruction for Sleep Lab. Staff: _____

_____

_____

_____

☐ Patient Informed ☐ Copy To _____

Date : _____

Additional Information needed: ☐ Yes ☐ No

Approved by: _____
Dr. J. Chien MD FRCPC

Please see other side for Instructions