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

YORK COUNTY SLEEP DISORDERS CENTRE
28 Main Street North
Newmarket, Ontario, L3Y 3Z7
phone: 905-895-3487 fax: 905-895-5364 e-mail: ycsl@rogers.com

Please book with Dr. Fried

Dr. _____ **(physician#** _____ **) requests a routine/URGENT:**
(please print)

- ❑ **initial sleep study followed by consultation if indicated**
- ❑ **initial sleep study only - no consultation**
- ❑ **repeat sleep study - must have sleep physician** ❑ **consultation** ❑ **assessment** **prior to scheduling**
- ❑ **consultation only**

Purpose of study: _____

Symptoms: snoring ❑ **witnessed apneas** ❑ **unrefreshing sleep** ❑ **fatigue** ❑ **somnolence** ❑
restless legs ❑ **insomnia** ❑ **other:** _____

Previous Sleep Studies? Yes / No Dates: _____

Special needs or considerations at time of study: _____

Medical History: _____

_____

Medications: _____

_____

Allergies: _____

Patient on Oxygen? Yes / No Level _____ **l/min**

Patient on CPAP? Yes / No Level _____ **cm H_2O**

- - - - - - - - - - - - - - - -

Patient Name _____ **(gender)** _____

Address _____

_____

Home # (**)** _____ _____ **Work # (** **)** _____ _____

Cell # (**)** _____ _____ **E-mail address:** _____

Date of Birth (d/m/y) _____ _____ _____ **Health Card #** _____ _____ _____ **Version Code** ___

Family Physician (if different) _____

Additional Reports to _____

REFERRING PHYSICIAN SIGNATURE: _____ **DATE:** _____

INITIAL STUDY APPROVED BY: _____ **DATE:** _____

rev 06/2012