OSLER SLEEP CLINIC

135 Queens Plate Dr. Suite 410, Etobicoke, Ontario Tel: (416) 231-5770
Please fax requisition to (416) 231-5229

Good Night
Great Day

Patient Information:

Last Name: _____ First Name: _____ M / F

OHIP# _____ V.C. _____ D.O.B. _____/_____/_____
D M Y

Telephone: (H) (_____) _____ (W) (_____) _____

Address: _____

Did the patient have a previous sleep study? Y / N When? _____
If yes, please provide copy of report

Services Requested:

□ Overnight Sleep Study and Consultation if results abnormal

□ Overnight Sleep Study and Consultation

□ Overnight Sleep Study □ Consultation Only

*Referral To: □ Dr. J. Rosenberg □ Dr. M. Huang □ Dr. M. Varkul □ Anyone to Consult
□ ENT Consultation – Dr. D. Hacker

□ MSLT/MWT □ Transcutaneous CO2 Monitor Respitrace
□ CPAP Titration □ Other: _____

Symptoms Leading to Referral:

□ Snoring □ with witnessed apneas □ Difficulty initiating and/or □ maintaining sleep

□ Unrefreshing sleep/Excessive Daytime Sleepiness □ Chronic Fatigue □ Narcolepsy

□ Restless legs and/or leg cramps □ Other_____

Provisional Diagnosis:

Other Medical History:

Medications:

Does the patient have any special needs? □ YES □NO Please describe:

Referring Physician Information:

Name: _____ OHIP Referring #:_____
(REQUIRED)

Telephone: _____ Fax: _____

Signature: _____ Date: _____
(REQUIRED)