Bluewater Sleep Disorder Clinic
1258 Michigan Ave.
Sarnia, On N7S 3Y2
Phone: (519) 332-5333
Fax: (519) 332-5444

REQUEST FOR SLEEP STUDY/CONSULTATION

REQUESTING PHYSICIAN TO COMPLETE
The information you provide is vital to the selection of the correct sleep study for your patient. PLEASE PRINT

Patient name: _____ Gender: M / F Street: _____

City: _____Postal Code_____Phone: _____ Email Address:_____

Health card #_____Version_____DOB:_____

Requesting physician: _____

Signature: _____Date: _____OHIP Billing #:_____
(MUST HAVE) (MUST HAVE)

Family Physician: _____

Symptoms Leading to Referral:

- ☐ Snoring
- **(Snoring alone is not an indication for a sleep study)**
- ☐ Snoring with apnea
- ☐ Somnolence
- ☐ Unrefreshing sleep
- ☐ Fatigue
- ☐ Sleep attacks
- ☐ CHF
- ☐ Difficulty staying asleep
- ☐ Frequent awakenings
- ☐ Daytime restless legs
- ☐ Repetitive movements during
- ☐ Abnormal behavior during sleep
- ☐ Difficulty getting to sleep
- ☐ Cataplexy
- ☐ Atrial Fibrillation

Special Needs:

- ☐ Hearing Impaired
- ☐ Translator
- ☐ Vision Impairment
- ☐ Caregiver Required
- ☐ Help Transfer
- ☐ Other: _____

Has the Patient had a Previous Sleep Study?
☐ Yes ☐ No

If Yes, please provide the date and location along with a copy of the study and any consultation report.
Date:
_____

Provisional Diagnosis:

- ☐ Obstructive sleep apnea
- ☐ Restless leg syndrome
- ☐Parasomnia
- ☐ Insomnia
- **(Insomnia alone is not an indication for a sleep study)**
- ☐ Periodic limb movement
- ☐ Narcolepsy

List of Medications:

ASSESSMENT REQUESTED:

- ☐ **Sleep Studies and Consultation**
- ☐ **Consultation – Only**
- ☐ **Other: _____**
- ☐ **Initial Sleep Study (PSG) Only (Consultation mandated if significant abnormality)**
- ☐ **Repeat Sleep Study (sleep physician consultation/assessment prior to study)**

Is This a Pre-Op Assessment? ☐ Yes ☐ No **Is This an Urgent Case?** ☐Yes ☐ No **If Yes, Specify Level of Urgency:**

Note: Cancellations must be given at least 24 hours prior to scheduled appointments. Should notice not be given a no show charge will be billed to the patient.

This requisition form can be taken to any licensed facility providing healthcare services including hospitals and IHFs, such as those listed on the IHF Program website: http://www.health.gov.on.ca/en/public/programs/ihf/facilites.aspx.