RVH
Royal Victoria Regional Health Centre

Sleep Study Requisition

201 Georgian Drive, Barrie, Ontario
Phone: 705-739-5604
Fax: 705-739-5651

PATIENT NAME: _____

DOB: _____

HCN: _____

Patient Information – Mandatory

Patient Name: _____ Gender: _____

Address: _____ Postal Code: _____

Referring MD: _____ Family MD: _____

List the patient's home phone number, and if applicable, one alternate number. For each number, use the tick boxes to indicate if the patient consents to be called at that number and/or if messages relating to his/her care & appointments can be left at that number:

Home: ☐ Call – can leave a message ☐ on voicemail ☐ with a person

Work/Other: ☐ Call – can leave a message ☐ on voicemail ☐ with a person

Patient Information (Must be completed)

Does this patient require any special assistance? ☐ Yes ☐ No

If Yes, please explain: _____

Has your patient had a prior sleep study in Ontario? ☐ Yes ☐ No

If yes, when: _____ Previous Sleep study? ☐ Diagnostic and/or ☐ Therapeutic

Please pick the type of study and the urgency of study

☐ Sleep study and consultation, if clinically indicated ☐ Sleep study only

☐ Routine ☐ Urgent ☐ Consult Only

Type of Study (Please select one box only)

Diagnostic Studies

☐ Initial – Diagnostic study-patient has had no prior sleep studies in Ontario

☐ Repeat – Diagnostic study - in consultation with Sleep Physician

☐ Multiple Sleep Latency Test (MSLT) in consultation with Sleep Physician

Therapeutic Study (Maximum of one per 24 month period)

☐ CPAP Titration ☐ CPAP Unit Replacement ☐ Oral Appliance Titration ☐ Post-surgery for OSA

Patient History / Co-Morbidities

☐ Diabetes ☐ Pacemaker ☐ Respiratory - Pt on home O2 ___lpm ☐ Seizure Disorder

☐ Neuromuscular Disorder: _____ ☐ Arrhythmia: _____

☐ Other:

Cardiac Co-Morbidities

☐ Recent Cerebrovascular Disease ☐ Unstable Ischemic Heart Disease

☐ Pulmonary Hypertension ☐ Congestive Heart Failure

☐ Other:

It is your responsibility to advise the patient of their appointment time.

Referring Physician:	Signature:	
Telephone Number:	Fax Number:	Billing #

For Office Use Only

☐ Initial Diagnostic Study ☐ Therapeutic Study ☐ Consult Only ☐ Repeat Diagnostic Study ☐ MSLT

Additional Information

☐ Non Routine – Paediatric (12 to younger than 16 yrs. Old) – parents or guardian must stay ☐ Non Routine – Extra Assistance ☐ Other: _____

Sleep Tech Initials: _____ Emp# _____ HRN# _____ ACCT# _____

R.SSR