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| **Health Avenue Sleep Medicine & CPAP Therapy** |

**Sleep Medicine Requisition Form  
(In person and Virtual Appointment)  
  
In-Lab and Home Sleep Study   
Serving Greater Toronto Area**

# REFERRING DOCTOR / HEALTH CARE PRACTITIONER

Referring Physician: Dr. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Billing #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_—\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_\_—\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MM DD YYYY

# PATIENT DEMOGRAPHIC

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OHIP #: \_\_\_\_\_\_\_\_—\_\_\_\_\_\_\_\_—\_\_\_\_\_\_\_\_\_\_ Version Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender:  Male  Female  Other

MM DD YYYY

Contact Phone #: (\_\_\_\_\_) \_\_\_\_\_\_\_—\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# REASON(S) FOR REFERRAL

Sleep Study & Consultation. Please specify:  Sleep Consultation Only

( ) Diagnostic Sleep Study  Home Study\* *(\*not covered by OHIP)*

( ) PAP Machine Titration  PAP Machine Re-Assessment

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# RELEVANT MEDICAL INFORMATION AND HISTORY

MI / CAD / CHF  Seizures / Epilepsy  Diabetes  Stroke

Asthma / COPD  Hypertension  Cardiac Arrythmia  Glaucoma

Others: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Urgency / Safety Critical Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Special Needs (Difficulty Communicating / Accessibility): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1975 Avenue Road, North York, Ontario M5M 4A1  
Phone (416) 440 8033 Fax: (416) 440 8034 Email: info@healthavenue.ca