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| **Health AvenueSleep 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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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