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:

( ) Diagnostic Sleep Study

( ) PAP Machine Titration

☐ Sleep Consultation Only

☐ Home Study* *(*not covered by OHIP)*

☐ PAP Machine Re-Assessment

_____

_____

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