Malvern Sleep Clinic

1371 Neilson Rd., Suite #306,
Scarborough, ON M1B 4Z8
Tel: 416-282-9119 • Fax: 416-282-4141
Email: malvernsleep@rogers.com

SLEEP STUDY REQUISITION

Please Complete All Sections in Full

PATIENT NAME: ______________________ **Sex:** ❑ Male ❑ Female

D.O.B. (dd/mm/yy) ____________ **HCN** ____________ **Version Code** ________

Address: ______________________ **Postal Code** ________

Home # ____________ **Bus. #** ____________ **Family Physician** ____________

ADULT SERVICES: ❑ Consultation with Sleep Studies as required

❑ Sleep Study only ❑ Consult Only ❑ CPAP follow up

Attention to: ❑ Dr. D. Ross ❑ Dr. M. Narayansingh ❑ Dr. J.S. Anthony ❑ Dr. A. Chelvanathan

PEDIATRIC SERVICE: ❑ Consultation with Dr. S. Bola and Sleep Studies as required

❑ Sleep Study only (must fill out past medical history in full, including all "no" responses, where appropriate, if sleep study only)

REASON FOR REFERRAL

❑ Snoring
❑ Apnea
❑ Insomnia
❑ Parasomnia
❑ Shift Work Problems
❑ Morning Headache
❑ Oral Appliance Follow up
❑ Non-Restorative Sleep
❑ Difficulties with attention/focus
❑ Fibromyalgia / Chronic Pain
❑ Narcolepsy
❑ MSLT/MWT
❑ CPAP follow up
❑ Adenoid/Tonsils Hypertrophied
❑ Obesity
❑ Nocturnal Seizures
❑ Restless Legs/Limb movements
❑ Post surgical follow up
❑ Hypersomnolence/fatigue

❑ Other - please describe: ______________________

PAST MEDICAL HISTORY:

Asthma ❑ Y ❑ N
COPD ❑ Y ❑ N
Arrhythmia ❑ Y ❑ N
Diabetes ❑ Y ❑ N
Hypertension ❑ Y ❑ N
CAD ❑ Y ❑ N
Angina ❑ Y ❑ N
Heart Failure ❑ Y ❑ N
Cardiomyopathy ❑ Y ❑ N
Alcoholism ❑ Y ❑ N
Depression ❑ Y ❑ N
Anxiety ❑ Y ❑ N
Stroke ❑ Y ❑ N
Parkinson's Disease ❑ Y ❑ N
Dementia ❑ Y ❑ N
Bruxism ❑ Y ❑ N
GERD ❑ Y ❑ N
Autism ❑ Y ❑ N
Seizures ❑ Y ❑ N
Trisomy 21 ❑ Y ❑ N
Congenital Heart Disease ❑ Y ❑ N
ADHD ❑ Y ❑ N
Pulmonary Hypertension ❑ Y ❑ N
Sickle Cell Disease ❑ Y ❑ No
Craniofacial Abnormalities ❑ Y ❑ N
Prader-Willi Syndrome ❑ Y ❑ N
Achondroplasia ❑ Y ❑ N

Other: ______________________

CURRENT MEDICATION: Has the patient ever had a sleep study in the past? ❑ YES ❑ NO ❑

____

REFERRING PHYSICIAN **Billing #** ____________

Name: ______________________

Mailing Address: ______________________

Phone #: ____________ **Fax #:** ____________

Signature: ____________ **Date:** ____________

STAMP

FOR OFFICE USE ONLY
Approved By: ______________________

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Name: ______________________________

Sleep Study Date: ______________________ **Time:** ____________

You have been booked for an overnight sleep study at the Malvern Sleep Clinic. During your study we will be monitoring your sleep patterns, including brain wave activity, respiration, heart rate and blood oxygen levels. Testing is done on the surface of the skin with electrodes and other monitoring equipment. No needles are involved.

In order to ensure that we are able to achieve the best possible results, please read and follow the instructions below:

- Please bring **comfortable sleep clothes** as well as **personal hygiene items**.
- Bring all your **medications** to the sleep lab, even if you do not have to take them while you are here. We prefer that you bring your actual medications.
- Remember to bring your **Health Card**
- We suggest you bring a book or magazine.
- Please wash your hair on the day of your study. For men, we request that you shave (moustache and beards exempted). For women, kindly remove all make-up.
- Do not consume any alcohol or caffeine for 24 hours before you come to the clinic. Examples of such food are coffee, tea, chocolate, etc.
- Leave any valuables at home. Malvern Sleep Clinic cannot assume responsibility for any loss of personal possessions.
- You will be asked to complete several questionnaires. If you require reading glasses, please bring these with you as well. The technician will help you with the questionnaires.

What if I cancel?
Cancellations are reasonable only for illness or personal emergencies. We ask that you notify the clinic 48 hours in advance if a cancellation is necessary. If advance notice is not given and we are unable to fill your spot, you will be charged an administrative fee.

What time can I sleep?
Once you've been "set up" you can sleep whenever you choose. We will try and accommodate you for your normal bedtime, within reason.

What time can I leave in the morning?
You will be awakened between 5:30-6:00 am the following morning. The equipment will be disconnected and there will be a short questionnaire to complete. Earlier wake-up times can be arranged if needed.

What if I need to go the washroom during the night?
You will be able to contact the technician by pressing a buzzer located beside your bed. The technician will simply "unplug" a device that is connected to the computers.

Any final instructions?
Please call the clinic to confirm your appointment as soon as possible. If you have any concerns, please contact us at **416-282-9119**, Monday to Friday between the hours of 9:00 am to 5:00 pm. During the evening, weekend feel free to leave a message at the same number.