



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. M. Narayansingh Dr. B. Marcarian Dr. A. Chelvanathan

Dr. S. Chaudhry Dr. Z. Adirim

REASON FOR REFERRAL

Snoring Non-Restorative Sleep Adenoid/Tonsils Hypertrophied

Apnea Difficulties with attention/focus Obesity

Insomnia Fibromyalgia / Chronic Pain Nocturnal Seizures

Parasomnia Narcolepsy Restless Legs/Limb movements

Shift Work Problems MSLT/MWT Post-surgical follow up

Morning Headache CPAP follow up Hypersomnolence/fatigue

Oral Appliance Follow up

Other - please describe: _____

PAST MEDICAL HISTORY:

| | | | |
|--------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------|
| Asthma <input type="checkbox"/> Y <input type="checkbox"/> N | Heart Failure <input type="checkbox"/> Y <input type="checkbox"/> N | Dementia <input type="checkbox"/> Y <input type="checkbox"/> N | ADHD <input type="checkbox"/> Y <input type="checkbox"/> N |
| COPD <input type="checkbox"/> Y <input type="checkbox"/> N | Cardiomyopathy <input type="checkbox"/> Y <input type="checkbox"/> N | Bruxism <input type="checkbox"/> Y <input type="checkbox"/> N | Pulmonary Hypertension <input type="checkbox"/> Y <input type="checkbox"/> N |
| Arrhythmia <input type="checkbox"/> Y <input type="checkbox"/> N | Alcoholism <input type="checkbox"/> Y <input type="checkbox"/> N | GERD <input type="checkbox"/> Y <input type="checkbox"/> N | Sickle Cell Disease <input type="checkbox"/> Y <input type="checkbox"/> N |
| Diabetes <input type="checkbox"/> Y <input type="checkbox"/> N | Depression <input type="checkbox"/> Y <input type="checkbox"/> N | Autism <input type="checkbox"/> Y <input type="checkbox"/> N | Craniofacial Abnormalities <input type="checkbox"/> Y <input type="checkbox"/> N |
| Hypertension <input type="checkbox"/> Y <input type="checkbox"/> N | Anxiety <input type="checkbox"/> Y <input type="checkbox"/> N | Seizures <input type="checkbox"/> Y <input type="checkbox"/> N | Prader-Willi Syndrome <input type="checkbox"/> Y <input type="checkbox"/> N |
| CAD <input type="checkbox"/> Y <input type="checkbox"/> N | Stroke <input type="checkbox"/> Y <input type="checkbox"/> N | Trisomy 21 <input type="checkbox"/> Y <input type="checkbox"/> N | Achondroplasia <input type="checkbox"/> Y <input type="checkbox"/> N |
| Angina <input type="checkbox"/> Y <input type="checkbox"/> N | Parkinson's Disease <input type="checkbox"/> Y <input type="checkbox"/> N | Congenital Heart Disease <input type="checkbox"/> Y <input type="checkbox"/> N | |

Other: _____

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

| | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|
| <p>REFERRING PHYSICIAN Billing # _____</p> <p>Name: _____</p> <p>Mailing Address: _____</p> <p>Phone #: _____ Fax #: _____</p> <p>Signature: _____ Date: _____</p> | <p>STAMP</p> |
| | <p>FOR OFFICE USE ONLY</p> <p>Approved By: _____</p> |

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Tel: 416-282-9119 • Fax: 416-282-4141

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.