

Sleep Laboratory Requisition

82 Buttonwood Avenue, Toronto ON M6M 2J5
 Tel: (416) 243-3631 Fax: (416) 243-3696
 www.westpark.org

Note: 24 hours notice required for cancellations or laboratory fees will be charged

Referring MD: _____
 Address: _____
 Tel: _____ Fax: _____
 Signature: _____

Ref.# _____

- Study ONLY
 Study and Consult
 Study and Follow-up

REASON(S) FOR STUDY

- Diagnostic Treatment / follow-up Change in symptoms

PREVIOUS STUDY?

- No Yes Date: _____ Location: _____

Previous Hospital Admission with Isolation Precautions?

- No Yes Organism/Disease: _____

CLINICAL DIAGNOSIS / SYMPTOMS

MEDICATIONS

SPECIAL CONSIDERATIONS Yes No

- | | |
|---|-----------------------------------|
| <input type="checkbox"/> Morbid obesity | <input type="checkbox"/> Language |
| <input type="checkbox"/> Mobility | <input type="checkbox"/> Hearing |
| <input type="checkbox"/> Incontinence | <input type="checkbox"/> Sight |
| <input type="checkbox"/> Tracheostomy | <input type="checkbox"/> Other |
| <input type="checkbox"/> G-Tube | _____ |

ASSISTIVE DEVICES Yes No

- Wheelchair
 Scooter
 Rollator
 Mechanical lift – bed transfer
 Sliding board – bed transfer
 Suction Equipment
 Other _____

STUDY CONDITIONS

- Diagnostic - Unassisted
 CPAP titration CPAP f/up Current Settings: _____ cmH₂O
 BiPAP/Ventilator Type: _____ Mode: _____ Settings: _____
 Oxygen (Sleep) Setting: _____ L/min

ADDITIONAL INFORMATION

Sleep Lab Use only

Date: _____ Time: _____ OP IP IP24hr Study Performed: _____