NOTE: Incomplete and / or unsigned requistions will be returned

MARKHAM STOUFFVILLE HOSPITAL CORPORATION

CENTRE FOR RESPIRATORY HEALTH REFERRAL
SLEEP DISORDERS LAB

Markham Site Booking Line: (905) 472-7614
Please Fax to: (905) 472-7618

☐ **Urgent** ☐ **Routine**

PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

Hospital MRN #: _____

Patient Name (Last, First): _____

Date of Birth (DD/MM/YYYY): _____ Sex: F M

Health Card #: _____ Version Code: _____

Address: _____ Postal Code: _____

Tel #: (Best Daytime): _____ Alt Tel #: _____

Email: _____

Date:	Referring MD	Signature	MD Phone #

Additional copies to:

Contact information for translator if required (Name & Number)

SLEEP STUDY REQUEST (MOHLTC Regulation)

Has the patient ever had a sleep study in Ontario? ☐ No ☐ Yes, Date: _____
If yes, please attach any pertinent information

Referral Request:

- ☐ Diagnostic Sleep Study only - the result will be sent to the referring physician
- ☐ Sleep Study and Sleep Specialist Consultation
- ☐ Sleep Specialist Consultation

Reason for Referral (Required information for prioritization):

_____

_____

Occupation: _____

- ☐ Sleepiness with Driving
- ☐ Excessive Daytime Sleepiness
- ☐ Unrefreshing Sleep
- ☐ Suspected Narcolepsy
- ☐ Witnessed apneas
- ☐ Insomnia
- ☐ Restless Legs
- ☐ Obesity
- ☐ Snoring
- ☐ Stroke
- ☐ Cardiac Complications e.g. _____
- ☐ Abnormal Sleep Behaviours e.g. _____
- ☐ Other: _____

Special Instructions

- ☐ Home Oxygen _____ L/min
- ☐ Night time medications
- ☐ Bariatric Bed
- ☐ Wheel Chair
- ☐ Other:

Please have the patient bring all current medications to the appointment and Ontario Health Card

MSH Use Only

Priority #: _____ **Date:** _____

Initials: _____

Clinic Date: _____ **Time:** _____

Lab Date: _____ **Time:** _____

- ☐ Diagnostic Sleep Study ☐ Repeat diagnostic study
- ☐ CPAP Titration - Starting pressure _____ cm H2O
- ☐ BiPAP Titration - Starting IPAP _____ cm H2O; EPAP _____; back up rate _____
- ☐ APAP assessment ☐ non-REM to REM ☐ Lateral to Supine
- ☐ Assessment of: ☐ Positional therapy ☐ Oral appliance
- ☐ MSLT
- ☐ MWT
- ☐ O2 titration: Starting flow: _____ L/min (if SpO2 <88% for 30 min, oxygen will be started and titrated to a saturation of 90 - 92% or _____
- ☐ Seizure Montage

Comments

_____

_____

Markham Stouffville Hospital
Centre for Respiratory Health
Located in the Markham Stouffville Health Center
377 Church St.
Room G07
Markham Ontario

Sleep Disorders Clinic (Sleep Specialist Consultation)

Bring your health card and all current medications.

You will be seen by the Sleep Disorder Clinic Physician.
Your appointment will take 30 - 60 minutes.

Sleep Study

Please Bring:

Robe
Two-piece pajamas
Slippers
Personal hygiene items (toothbrush, toothpaste, etc.)
Medication (continue taking them as usual)
Activities to help you relax, for example:

- ✓ books/magazines
- ✓ knitting/needlepoint
- ✓ puzzles/crosswords
- ✓ music

Snacks are not provided by the clinic.
Diabetic patients should bring snacks or juices.

If you are on a nasal or Continuous Positive Airway pressure (CPAP) unit, please bring it with you.

Do not:

Drink any caffeinated beverages after 3:00 p.m.
Bring large sums of money or jewelry with you
Nap during the day
Use hair spray or gel

If you have excessive daytime sleepiness, make sure that someone drives you to and from your sleep study.

Parking will be validated for your sleep study appointment only.
Please park in visitor parking lot #1 accoss from 377 Church St.
Please note there is no parking validation for physician consultation appointments.