MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

SLEEP LAB
825 Coxwell Avenue
Toronto, ON M4C 3E7

T:416-469-7777 F:416-469-7717

PLEASE PRINT CLEARLY

Patient Name: _____ **D.O.B.(dd/mm/yy)** _____

Address: _____ City: _____ Postal Code: _____

Telephone number(s): H:_____ B:_____ C:_____

Health Card #: _____ **V.C.** ____ Gender: M / F

Referring Physician: _____ **Billing Number:** _____

Address: _____

Fax: (_____)_____ Phone: (_____)_____

Signature: _____
(Required for testing)

*****COMPLETE THOROUGHLY TO EXPEDITE BOOKING*****

Confidential message can be left on the voice mail: □ ***YES*** □ ***NO***

Please check:
□ Patient **NEVER** had a sleep study before.

□ Patient had a sleep study at **MGH/TEGH** before. When? _____

□ Patient had a sleep study elsewhere. When and where? _____

Sleep Testing, Please check one:
□ Sleep Study with CPAP titration (if necessary) & consult. □ CPAP reassessment & consult

Please check all that apply: □ Apneas □ Hypersomnolence □ Heart disease □ Stroke

□ Diabetes □ Seizures □ Sleepy while driving □ COPD □ Depression □ On opioids

□ Insomnia ***WITH*** suspicion of another sleep disorder.

Is the patient ambulatory? □Yes □ No **BMI:** _____ Kg/m^2

Occupation: _____ **Is Occupation safety sensitive?** □ Yes □ No

Initial consultation might be necessary to assess eligibility under new Ministry Guidelines. Patients will be contacted once fax is received.