

SLEEP LAB REQUISITION

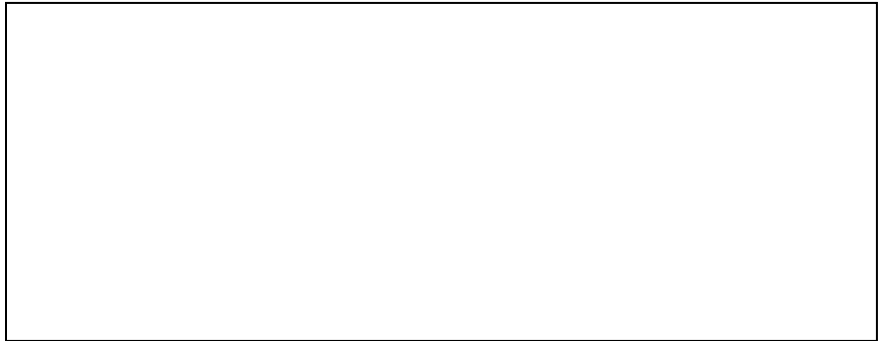
Referrals accepted via **Oceans online referral** or to **Fax 416-469-7717**



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<https://www.tehn.ca/programs-services/medicine/respirology-chest-centre>



Office use:

- Sleep Study Appointment Date and Time:** _____
- Sleep Clinic follow up Appointment Date and Time:** _____

Sleep Testing Requested: Sleep Study & Consultation Sleep Consultation Only

Symptoms: Snoring Hypersomnolence Other

Working diagnosis: _____

Does the patient's occupation raise a **safety concern** if the patient has sleep-disordered breathing? Yes No

Patient's occupation: _____

Has the patient EVER had a sleep study in Ontario before? Yes No Unknown

(OHIP only permits 1 Diagnostic (first time) sleep study per patient per lifetime. Excess studies will result in the patient being charged the OHIP technical fee of \$370.75 unless the patient is seen in consultation by the sleep physician first.)

Is this consult request for CPAP renewal? Yes No

Available to come on short notice? Yes No

Medications:

Notes:

The MGH **Sleep study information sheet** will be forwarded to the patient. It is also available on our website.

We **do not accept consultations for insomnia** that are not related to sleep-disordered breathing (ie: like OSA)

Patients must be **independently mobile** and able to toilet themselves to have a sleep study.

"I agree that the above tests may be adjusted if needed depending on the clinical circumstances. Consultation or repeat referral may be required for additional testing."

Physician Signature: _____

Date: _____

Physician name (Print): _____

Billing #: _____

Tel: _____

Copies to: _____

Fax: _____