West Park HEALTHCARE CENTRE
Get your life back.

Patient Information

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: _____ Ref.# _____

Address: _____

Tel: _____ Fax: _____

Signature: _____

☐ **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
Morbid obesity	☐	☐
Mobility	☐	☐
Incontinence	☐	☐
Tracheostomy	☐	☐
G-Tube	☐	☐
Language	☐	☐
Hearing	☐	☐
Sight	☐	☐
Other	☐	☐

_____

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: _____ cmH_2O
☐ BiPAP/Ventilator Type: _____ Mode: _____ Settings: _____
☐ Oxygen (Sleep) Setting: _____ L/min

ADDITIONAL INFORMATION

_____

Sleep Lab Use only

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