Bluewater
SLEEP DISORDER CLINIC

☐1258 Michigan Ave
SARNIA ON N7S 3Y2
Phone 519-332-5333
FAX 519-332-5444

www.bluewatersleep.ca
staff@bluewatersleep.ca

☐17 Park Ave East
CHATHAM ON N7M 3V3
Phone 519-352-7378
FAX 519-352-7376

REQUISITION FORM

PATIENT INFORMATION:

Name _____ **Height** _____ **Weight** _____ **M / F**

HCN _____ **Version** _____ **Birthdate** _____ **Age** _____

Home Phone _____ **Cell Phone** _____ **Email** _____

Street _____ **City** _____ **Postal Code** _____

HEALTH CARE PROVIDER INFORMATION:

Name _____ **OHIP billing #** _____ **Phone** _____

Fax _____ **Email** _____ **Signature** _____

Family Health Care Provider _____ **Date** _____

SERVICES REQUESTED: **This lab will contact your patient and schedule the services you request below:**

€ **Sleep Studies and Consultation** € ***Consultation Only** € **Sleep Studies Only**

***All patients with a history of sleep studies must be referred for a consultation prior to additional sleep studies**

Provisional Diagnosis _____

Other Medical History _____

Medications _____

Did the patient have a previous sleep study? Y / N **When** _____ **Location** _____
If yes, please provide a copy of report.

Does the patient have any special needs? € YES **NO €** **Please describe:** _____

Symptoms Leading to Referral:

- € Obstructive Sleep Apnea
- € Snoring with apnea
- € Unexplained somnolence
- € Unrefreshing sleep/fatigue
- € Periodic limb movement
- € Parasomnia
- € Insomnia
- € Shift work
- € Frequent awakenings
- € Difficulty getting to/staying asleep
- € Restless leg
- € Repetitive movements during sleep
- € Cataplexy
- € Other _____

This requisition form can be taken to any licensed facility providing healthcare services including hospitals and IHF's such as those listed on the IHF Program website: http://health.gov.on.ca/en/public/programs/ihf/facilities.aspx

Clinic Use Only: Diagnostic PSG_____ **CPAP Titration**_____ **Other**_____ **Consultation**_____

Sleep Physician Approval _____ **Date** _____ **IVR** _____