Etobicoke-Brampton Sleep Clinic

106 Humber College Blvd., Suite 202, Etobicoke, Ontario M9V 4E4
Phone (416) 742-0680 • Fax (416) 742-0681

Name: _____

Sleep Study Date: _____ **Time:** _____

You have been booked for an overnight sleep study at the Etobicoke-Brampton Sleep Clinic. During your study we will be monitoring your sleep patterns, including brain wave activity, respiration, heart rate and blood oxygen levels. Testing is done on the surface of the skin with electrodes and other monitoring equipment. No needles are involved.

In order to ensure that we are able to achieve the best possible results, please read and follow the instructions below:

- Please bring **comfortable sleep clothes** as well as **personal hygiene items**.
- Bring all your medications to the sleep lab, even if you do not have to take them while you are here. We prefer that you bring your actual medications.
- Remember to bring your **Health Card**.
- We suggest you bring a book or magazine.
- Please wash your hair on the day of your study. For men, we request that you shave (moustache and beards exempted). For women, kindly remove all make-up.
- Do not consume any alcohol or caffeine for 24 hours before you come to the clinic. Examples of such food are coffee, tea , chocolate, etc.
- Leave any valuables at home. Etobicoke-Brampton Sleep Clinic cannot assume responsibility for any loss of personal possessions.
- You will be asked to complete several questionnaires. If you require reading glasses, please bring these with you as well. The technician will help you with the questionnaires.

What if I cancel?
Cancellations are reasonable only for illness or personal emergencies. We ask that you notify the clinic 48 hours in advance if a cancellation is necessary. If advance notice is not given and we are unable to fill your spot, you will be charged an administrative fee.

What time can I sleep?
Once you've been "set up" you can sleep whenever you choose. We will try and accommodate you for your normal bedtime, within reason.

What time can I leave in the morning?
You will be awakened between 5:30-6:00 am the following morning. The equipment will be disconnected and there will be a short questionnaire to complete. Earlier wake-up times can be arranged if needed.

What if I need to go to the washroom during the night?
You will be able to contact the technician by pressing a buzzer located beside your bed. The technician will simply "unplug" a device that is connected to the computers.

Any final instructions?
Please call the clinic to confirm your appointment as soon as possible. If you have any concerns, please contact us at **(416) 742-0680**, Monday to Friday between the hours of 9:00 am to 5:00 pm. During the evening, weekend feel free to leave a message at the same number.

Etobicoke-Brampton
Sleep Clinic

106 Humber College Blvd., Suite 202
Etobicoke, Ontario M9V 4E4
Tel: 416-742-0680 · Fax: 416-7420681
Email: ebsleepclinic1@bellnet.ca

SLEEP STUDY REQUISITION

Please Complete All Sections in Full

PATIENT NAME: _____ **Sex:** ❑ **Male** ❑ **Female**

D.O.B. (dd/mm/yy) _____ **HCN** _____ **Version Code** _____

Address: _____ **Postal Code** _____

Home # _____ **Bus. #** _____ **Family Physician** _____

ADULT SERVICES: ❑ Consultation with Sleep Studies as required
❑ Sleep Study only ❑ Consult Only ❑ CPAP follow up

Attention to: ❑ Dr. C. Rodriguez ❑ Dr. T. Kukreja ❑ Dr. H. Singh ❑ First Available Doctor

PEDIATRIC SERVICE: ❑ Consultation with sleep study as required ❑ Sleep Study Only
(must fill out past medical history in full, including all "no" responses, where appropriate, if sleep study only)

Attention to: ❑ Dr. S. Bola ❑ Dr. K. Mehta ❑ First Available Doctor

REASON FOR REFERRAL

❑ Snoring
❑ Witnessed Apnea
❑ Insomnia
❑ Parasomnia
❑ Shift Work Problems
❑ Morning Headache
❑ Oral Appliance Follow up
❑ Non-Restorative Sleep
❑ Difficulties with attention/focus/concentration
❑ Fibromyalgia
❑ Narcolepsy
❑ MSLT/MWT
❑ CPAP follow up
❑ Daytime Sleepiness
❑ Adenoid/Tonsils Hypertrophied
❑ Obesity
❑ Nocturnal Seizures
❑ Restless Legs/Limb movements
❑ Post surgical follow up
❑ Hypersomnolence/fatigue

Other - please describe: _____

PAST MEDICAL HISTORY:

Asthma	❑ Y ❑ N	Heart Failure	❑ Y ❑ N	Dementia	❑ Y ❑ N	ADHD	❑ Y ❑ N
COPD	❑ Y ❑ N	Cardiomyopathy	❑ Y ❑ N	Bruxism	❑ Y ❑ N	Pulmonary Hypertension	❑ Y ❑ N
Arrhythmia	❑ Y ❑ N	Alcoholism	❑ Y ❑ N	GERD	❑ Y ❑ N	Sickle Cell Disease	❑ Y ❑ N
Diabetes	❑ Y ❑ N	Depression	❑ Y ❑ N	Autism	❑ Y ❑ N	Craniofacial Abnormalities	❑ Y ❑ N
Hypertension	❑ Y ❑ N	Anxiety	❑ Y ❑ N	Seizures	❑ Y ❑ N	Prader-Willi Syndrome	❑ Y ❑ N
CAD	❑ Y ❑ N	Stroke	❑ Y ❑ N	Trisomy 21	❑ Y ❑ N	Achondroplasia	❑ Y ❑ N
Angina	❑ Y ❑ N	Parkinson's Disease	❑ Y ❑ N	Congenital Heart Disease	❑ Y ❑ N		

Other: _____

CURRENT MEDICATION: _____

Has the patient ever had a sleep study in the past? ❑ YES ❑ NO

REFERRING PHYSICIAN **Billing #** _____

Name: _____

Mailing Address: _____

Phone #: _____ **Fax #:** _____

Signature: _____ **Date:** _____

STAMP

FOR OFFICE USE ONLY
Approved By: