

# *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?**

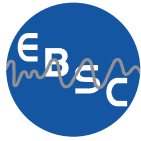
You will be awakened between 5:30-6:00 am the following morning. The equipment will be disconnected and there will be a short questionnaire to complete. Earlier wake-up times can be arranged if needed.

## **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

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

Other - please describe:

PAST MEDICAL HISTORY:

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

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: