Oshawa Clinic
Centre for Sleep Medicine
13 Charles Street, Oshawa, Ontario, L1H 4X5
Phn# (905) 721-4052 Fax# (905) 721-4054

SLEEP LAB REFERRAL REQUISITION

Physicians

Dr. Arunabh Sharma, MD, FRCPC, DABSM
Dr. David Ross, MD, FRCPC
Dr. Ted. Monchesky, MD, FRCPC
Dr. Robert Kassel, MD, FRCSC

Patient Information

Name:_____
DOB:_____
HIN#_____ VC_____
Home #_____
Alternate #_____
Address _____

Please indicate type of referral:

- ○ Consultation; Diagnostic Sleep Study; and CPAP Titration if needed
- ○ Sleep Study Only ○ Cpap Titration with Assessment ○ Consultation Only

Please indicate at the time of the booking if you request a specific physician, if your patient has seen one of our sleep specialists in the past, or if your patient is under 16 years of age.

If yes to any of the above, please specifiy_____

Consult Date:_____ Sleep Study Date:_____

Clinical Information

Reason for Referral
_____
_____
_____
Other medical history: _____

○ Snoring ○ Sleep Apnea ○ Restless Legs Syndrome ○ Parasomnia
○ Nocturnal Seizures ○ Hypersomnolence ○ Periodic Leg Movement Disorder ○ Unrestorative Sleep
○ Difficulty Initiating and Maintaining Sleep

Medications: _____
_____
_____

Has a sleep study been done previously? YES____ NO____ If yes, when? _____
Does the patient have any special needs (ie. O2 user, wheelchair, other disability)? YES _____NO _____
Please make reference to special needs when calling to book appointment Specify _____
Please ask your patient to bring his/her HEALTH CARD!

Referring Physician Information

Printed Name:_____ Billing No:_____ Date:_____
Telephone #_____ Fax#_____
Address:_____
Physician Signature_____

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