

# CENTRE FOR SLEEP DISORDERS

## Pickering

1099 Kingston Road, Unit 5D  
Pickering, Ontario L1V 1B5  
Tel: 905-420-9626 Fax: 905-420-3279

## Whitby

320 Byron St. South, Suite 100  
Whitby, Ontario L1N 4P8

Tel: 905-668-5590 Fax: 905-420-3279

## Bowmanville

222 King Street East Suite 2101, South Wing  
Bowmanville, Ontario L1C 1P6  
Tel: 905-697-0832 Fax: 1-905-420-3279

Date (D/M/Y) \_\_\_\_\_

## REFERRAL FORM

Please fill all sections and fax to 905-420-3279. We will contact the patient with an appointment date. Please see back for instructions.

### PATIENT'S INFORMATION

Patient's Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

(D/M/Y)

HIN: \_\_\_\_\_ VC: \_\_\_\_\_

Address: \_\_\_\_\_

Office Stamp: \_\_\_\_\_

Telephone: \_\_\_\_\_

Family Physician Name: \_\_\_\_\_

Referring Physician if Different from Above: \_\_\_\_\_ Billing No: \_\_\_\_\_

### REASON FOR REFERRAL Is this study ROUTINE URGENT

<input type="checkbox"/> Snoring	<input type="checkbox"/> Sleep Apnea	<b>Does the patient have any?</b>
<input type="checkbox"/> Daytime Fatigue / Sleepiness	<input type="checkbox"/> Restless Sleep	<input type="checkbox"/> Mobility Problems
<input type="checkbox"/> Excessive Daytime Sleepiness	<input type="checkbox"/> Periodic Limb Movements	<input type="checkbox"/> Hearing Impairment
<input type="checkbox"/> Restless Leg Syndrome	<input type="checkbox"/> Night Terrors	<input type="checkbox"/> Language Barrier
<input type="checkbox"/> Non-restorative Sleep	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Vision Impairment
<input type="checkbox"/> Difficulty Waking Up	<input type="checkbox"/> Frequent Nocturnal Awakenings	<input type="checkbox"/> Require a Caregiver/Parent
<input type="checkbox"/> Other _____		

### MEDICAL HISTORY

Hypertension  Angina  Pediatric: ADHD  Diabetes  Depression  Fibromyalgia  
 Epilepsy  Other \_\_\_\_\_  
 List of Medications \_\_\_\_\_

### REQUEST FOR

Sleep Study  
 Consultation  
 Sleep Study followed by consultation  
 Blood Pressure Monitoring Sleep Study

#### Additional Notes:

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Referring Physician Signature: \_\_\_\_\_

Has the patient had previous sleep studies?  YES  NO If yes, please send previous results.

Initial: \_\_\_\_\_ DATE: \_\_\_\_\_

Instructions: \_\_\_\_\_

# Instructions for a Sleep Study

The Centre for Sleep Disorders will call you with an appointment date for a sleep study.

## What is done during a sleep study?

When you arrive you will be asked to complete some questionnaires. The set-up includes the placement of 2 respiratory belts; surface electrodes on the head, face, chest, and legs; and an airflow sensor under the nose. After lying in bed a finger probe will be placed on your finger to measure the oxygen saturation in your blood. You will then be directed to some calibration movements followed by turning the lights off and starting the test.

If you have to use the washroom during the test, it is not a problem. Call the Sleep Technologist who will disconnect the main box easily and you can quickly get to the washroom.

You will be awakened around 6:00 am. It takes about 15 minutes to take the electrodes and sensors off and to fill out a brief questionnaire. If you must be awakened by a specific time in the morning, please notify the Sleep Technologist upon your arrival.

## TEST INSTRUCTIONS

To ensure the most accurate results, please follow these instructions carefully.

- 1) **Bring your health card.**
- 2) **Arrive on time.** Your appointment time is planned to permit time for set-up, which takes approximately 45 minutes per patient. The Sleep Technologist will set-up two more patients before starting the test. Therefore, the usual time to turn the lights off and start the test is around 11:00 pm. If you require going to sleep before the rest of the patients are set-up, please inform the Sleep Technologist when you arrive.
- 3) **Prepare for the test.** Take a shower prior to arriving to the centre. Hair should be free of any styling gel, spray or cream. No shower facilities are available at the centre. Gentlemen, please shave if you do not have a beard. Ladies please remove fingernail polish.
- 4) **Do not consume** any caffeine after 3 pm. This includes coffee, tea, chocolate, cola's etc.. Do not consume any alcohol on the day of your test.
- 5) **Do not nap** on the day of your test.
- 6) **Pack your necessary items.**

a) You must bring nightwear.	b) Personal toiletries.
c) Usual medications and a list of your medications.	d) Bring your own pillow and blanket.
e) <b>CPAP patients</b> bring your own mask, hose and headgear.	f) Indoor slippers for use in the lab
g) Bottle of water to drink	

**Important:** If you are unable to keep your appointment, please give us at least 2 working days notice. Otherwise you will be charged for a missed appointment fee of **\$100.00**.

**Please do not bring valuables as we cannot guarantee their security.**