fraserhealth

SLEEP STUDY REQUISITION
Abbotsford Regional Hospital

FAX to ARHCC Sleep Lab Intake (604-851-4993)

PATIENT INFORMATION:

Last name:	First name:
Date of birth (DD/MM/YYYY):	PHN:
Gender: ☐ Female ☐ Male ☐ Other Pronouns:	Primary phone:
Email:	Secondary phone:
Address:	
Family physician:	Date referred by GP:

REASON FOR REFERRAL: *(Check all that apply)*

- ☐ Suspected sleep disordered breathing (SDB)
- ☐ Suspected parasomnias or REM behavior disorder
- ☐ Suspected narcolepsy or Idiopathic hypersomnolence
- ☐ Suspected RLS/PLMD or other movement disorder
- ☐ Reassess SDB with oral appliance or positional therapy
- ☐ Reassess SDB without the use of CPAP/BiPAP
- ☐ Titration, to optimize pressure
- ☐ Central/complex apneas, for advanced PAP titration (BiPAP ST, ASV, AVAPS/iVAPS)
- ☐ Others _____

RELEVANT PATIENT and MEDICAL HISTORY:

TEST REQUESTED:

☐ Overnight PSG	☐ Split night	☐ MSLT (prior overnight PSG required)	☐ MWT
☐ CPAP/BiPAP titration	☐ BIPAP only	☐ BIPAP AVAPS/iVAPS	☐ ASV

Other instructions:

☐ Supplemental oxygen ☐ $TcCO_2$ monitoring ☐ ABG ☐ Oral appliance ☐ Positional therapy

Special Instructions:

OTHER CONSIDERATIONS: (Required)

Needs interpreter	☐ No	☐ Yes	Specify language:
Needs assistance in getting into bed and/or walking to washroom	☐ No	☐ Yes	Specify: *(e.g., lift needed)*
Patient is over 300 lbs and needs bariatric bed	☐ No	☐ Yes	
Any other special assistance or consideration?	☐ No	☐ Yes	Specify: *(e.g., with cognitive disability, needs overnight caregiver)*

PRIORITY

☐ **Urgent / Priority 1** (within 1 to 4 weeks) Major daytime sleepiness (Epworth Sleepiness Scale (ESS) 10 or greater) and one or more of the following: (1) Safety Occupation, (2) Co-morbid disease, or (3) Overnight Home Oximetry of > 30 Desaturation/hr with 4% desaturation.	☐ **Priority 2** (within 2 months) Major daytime sleepiness (ESS 10 or greater) but no co-morbid disease or high risk occupation.	☐ **Priority 3** (within 6 months) No major daytime sleepiness, no co-morbid disease, no safety critical occupation

INFORMATION NEEDED PRIOR TO BOOKING:

1. Sleep History Consultation **(required)**
2. Previous sleep assessments *(if any)*
   - ☐ Level 1 PSG
   - ☐ Level 3 sleep study
   - ☐ Overnight oximetry
   - ☐ Recent PAP download

REFERRING SPECIALIST:

Name:	
Title:	MSP number:
Phone number:	Fax number:
Signature:	Date (DD/MM/YYYY):