* ***The focus of the sleep laboratory at present is the evaluation of complex respiratory and neurological problems. Sleep study has limited value in the evaluation of behavioural disorders, such as insomnia. At present we are not evaluating otherwise healthy children with sleep related behavioural disorders.***
* ***Please print and provide complete information to avoid delays and to assist in prioritizing patients***

**DATE OF REFERRAL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT IDENTIFICATION:**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HCN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB (yy/mm/dd):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_ Interpreter required: **□** No **□** Yes, Language spoken:\_\_\_\_\_\_\_\_\_\_

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

Parent/guardian name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alternate #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REQUESTED SERVICE:** Pease note, patients will be triaged to lab or clinic on the basis of the information provided.

**□** Consultation and sleep study as required **□** Sleep study only

**□** Urgent (please explain):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REASON FOR REFERRAL (please include medical diagnoses/medical history):**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CHECK ALL THAT APPLY:**

NOCTURNAL SYMPTOMS:

**□** Snoring/Noisy resp **□** Cyanosis

**□** Pauses/Apnea **□** Gasping

**□** Mouth breathing **□** Choking

**□** Morning headache **□** Seizure

**□** Limb Movements **□** Awakenings

**□** Restless sleep **□** Enuresis

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DAYTIME SYMPTOMS/SIGNS:

**□** Excessive sleepiness **□** Fatigue

**□** Irritability **□** Hyperactivity

**□** Poor concentration **□** Anxiety

**□** Poor school performance

**□** Enlarged tonsils / adenoids

**□** Family Hx of sleep disordered breathing

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DIAGNOSES:

**□** Craniofacial abn **□** Obesity

**□** Seizure/Epilepsy **□** ADHD

**□** Cerebral palsy **□** Arrythmia

**□** Congenital Heart Dz **□** BPD

**□** Neuromuscular Dz **□** Asthma

**□** Prader-Willi **□** Trisomy-21

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST MEDICAL HISTORY:**

Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BMI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tonsils removed: **□** No **□** Yes, when:\_\_\_\_\_\_ Adenoids removed: **□** No **□** Yes, when:\_\_\_\_\_

ENT following: **□** No **□** Yes, who:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other physicians involved in care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous sleep study: **□** No **□** Yes, when:\_\_\_\_\_\_ . If yes: **□** LHSC **□** Elsewhere (please include a copy of the report)

Is the patient on oxygen: **□** No **□** Yes, How much\_\_\_\_\_\_\_\_\_\_ What method\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the patient sleep with respiratory technology: **□** None OR Yes - **□** CPAP **□** BiPAP **□** Invasive-Ventilation

If yes: Mode:\_\_\_\_\_\_\_ Settings (IPAP, EPAP,Rate):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Interface:\_\_\_\_\_\_\_\_\_\_\_\_

**REFERRING MD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**BILLING NUMBER:\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

OFFICE USE ONLY: TRIAGE LOCATION: STAFFING LAB STUDY TYPE

**□** URGENT **□** Clinic **□** Routine **□** Baseline

**□** Semi-Urgent **□** LAB **□** Complex Resp **□** CPAP **□** BiPAP

**□** Routine **□** Clinic or Lab **□** Complex Med/Behav **□** O2 **□** Split

 **□** Requires 1:1 **□** MSLT