BC CHILDREN'S HOSPITAL
An Agency of the Provincial Health Services Authority

REQUISITION FOR SLEEP MEDICINE EVALUATION

Room 1C42 - 4480 Oak Street
Vancouver, BC, V6H 3V4
Phone: 604-875-3549

Name:

DoB
Hospital #
PHN
Address

Phone: _____

Fax completed form to: 604-875-3293 Translator: Y/N, Language: _____

□ ***Urgent (please discuss with Sleep/Respiratory Physician)***

Tests

□ Consultation by Sleep Physician only
□ Consultation + Sleep Laboratory testing (if needed)
□ Polysomnography only*
□ Multiple Sleep Latency Test *(Requires Consultation by Sleep Physician)*
□ No preference / TBD by Sleep Clinic

□ Overnight Oximetry (□ *Screening for severe OSA or* □ *Monitoring of oxygenation)* Inpatient? Yes† □ No □
†Contact Ward RT, Pager 41 -01001

Please complete this section for Consultation and Polysomnography (not overnight oximetry)

Physician requested: □ Ipsiroglu □ Lee □ Wensley □ Wright □No preference

All patients may be considered for Virtual Health evaluation, unless otherwise requested.

**The following select patients may be triaged to have a sleep study without a consultation to expedite evaluation:*
□. Patients meeting the following criteria: >= 2 years of age, cooperative, no MAJOR medical/psychiatric comorbidities (incl. craniofacial abnormalities), only suspected OSA or other sleep-disordered breathing.
□. Cases discussed with and approved by a sleep physician.

Previous sleep assessment or sleep study? □ Yes □ No □ Unknown

Question to be assessed (check all that apply):

□ Obstructive Sleep Apnea (OSA)
□ Other sleep-disordered breathing
e.g. central sleep apnea, hypoventilation, etc.
□ Hypersomnia
e.g. narcolepsy, idiopathic hypersomnia, etc.
□ Circadian rhythm disturbance
□ Insomnia
□ Restless legs syndrome
□ Parasomnias e.g. sleep terrors
□ Other (specify): _____

Please complete for all requests:

Pertinent clinical history: _____

_____

Current Medications (including OTC): _____

Allergies: _____

Infection Control Precautions? Y/N If yes, details: _____

Referring provider name:	Specialty:	Billing number:	Signature:	Date
_____	_____	_____	_____	_____

Additional copies to: _____

***** Please note that we will contact the patient/family with the appointment date and time *****