fraserhealth

SLEEP STUDY REQUISITION
Abbotsford Regional Hospital

Form ID: MSXX106223C Rev: July 8, 2024 Page: 1 of 1

For approved sleep specialist use only
Note: GP or NP and other specialist, please use the ARH Sleep Clinic Referral

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 (dd/mm/yyyy)

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
+ ☐ MSLT (prior standalone overnight PSG required)
+ ☐ MWT
+ ☐ Administer supplemental O_2 when the patient exhibits sustained hypoxemia.

Note: Adding supplemental O_2 during diagnostic test may underestimate the AHI result.

☐ Titration *(specify below)*
☐ CPAP/BiPAP S/ST
☐ BiPAP S/ST only (No CPAP)
☐ AVAPS/iVAPS
☐ ASV
☐ Supplemental O_2 if hypoxemia persists despite optimal titration

Other instructions: ☐ $TcCO_2$ monitoring ☐ ABG ☐ Oral appliance ☐ Positional therapy ☐ + Flexor Arm EMG

Special Instructions:

OTHER CONSIDERATIONS (Required)

Need interpreter? ☐ No ☐ Yes, specify language

Patient is over 350 lbs and needs bariatric bed? ☐ No ☐ Yes

Need assistance in getting into bed and/or walking to washroom? ☐ No ☐ Yes, specify (e.g., lift *needed)*

Any other special assistance/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 1 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):

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