Interior Health

POLYSOMNOGRAPHY REQUISITION

Royal Inland Hospital
Neurodiagnostic Services

Phone: 250-314-2100 ext. 3586 Fax: 250-314-2798

Patient Name *(last)* _____

(first) _____

DOB *(dd/mm/yyyy)* _____

PHN _____ MRN _____

Account/Visit # _____

IH USE ONLY

Sex: ☐ Male ☐ Female Phone _____ Date Received _____

Address _____

Request

☐ **1. Sleep study** (with results to be followed up by ordering physician)

☐ Polysomnogram ☐ MSLT (sleep specialist) ☐ MWT (sleep specialist)

☐ Diagnostic

☐ Therapeutic (please attach any previous study below)

☐ *CPAP* ☐ *BIPAP* ☐ *ASV* ☐ *VAPs* ☐ *Oxygen* ☐ *Dental device* *Settings* _____

☐ Currently tolerating CPAP settings

☐ Yes ☐ No

☐ **2. Sleep physician referral** – Fax this form, medical profile and medication list to Sleep lab (250-314-2798)

Reason for referral

☐ Suspected OSA
(STOP BANG score: _____)
(Snoring, Tired, Observed Apneas, High BP, BMI greater than 35, Age greater than 50, Neck greater than 40 cm, Gender = Male)

☐ Suspected Central Sleep Apnea
☐ Suspected Hypoventilation
☐ Restless Legs/Limb movement

☐ Suspected Narcolepsy
☐ Abnormal sleep behaviours/seizure disorder
☐ Insomnia

Pertinent Clinical History (for triage purposes)

- ***Referring physician to send any previous sleep studies/oximetries with requisition***

☐ Cerebrovascular disease
☐ Atrial Fibrillation
☐ Ischemic Heart Disease
☐ Congestive Heart Failure
EF = _____

☐ Safety critical occupation*
☐ Excessive daytime sleepiness
☐ Pregnancy
☐ Fallen asleep while driving
☐ Dialysis patient

☐ COPD
☐ Pulmonary Hypertension
☐ Neuromuscular disease
☐ ILD

*Vehicle/heavy machinery operator OR any job with potential for injury. Please specify _____

Medications (or attach medication list)

☐ Antidepressants ☐ Antipsychotics ☐ Opiates ☐ Benzodiazepines
☐ Stimulants ☐ Alcohol ☐ Cannabis products ☐ Sleep Aids

Please specify _____

The sleep lab is a clinical area without nursing or personal care support. If your patient requires assistance with any of the following they must be accompanied by a care giver for support.

☐ **Ht** _____ **Wt** _____

☐ Cognitive support *(Specify)* _____

☐ Behavioral support *(Specify)* _____

☐ Medication or Diabetes management

☐ Manual transfers, toileting assistance or incontinence support

Date (dd/mm/yyyy)	Time (24 hour)	Name/Signature	Designation/College ID #
/ /			

FOR LAB ONLY

Date (dd/mm/yyyy)	Time (24 hour)	Name/Signature	Designation/College ID #
/ /			

Permanent part of the health record

Clear Form Print Form

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IH USE ONLY

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the ***most appropriate number*** for each situation:

0 = would ***never*** doze
I = ***slight*** chance of dozing
2 = ***moderate*** chance of dozing
3 = ***high*** chance of dozing

Situation	Chance of Dozing
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g., a theatre or meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
	0 **/ 24**

If we have a cancellation would you be available on short notice (within 24 hours) to come for a test? ☐ Yes ☐ No

Acronyms

MSLT	Multiple Sleep Latency Test	**BMI**	Body Mass Index
MWT	Maintenance Wakefulness Test	**EF**	Ejection Fraction
CPAP	Continuous Positive Airway Pressure	**BP**	Blood Pressure
BiPAP	BiLevel Positive Airway Pressure	**COPD**	Chronic Obstructive Pulmonary Disease
ASV	Adaptive Servo Ventilator	**ILD**	Interstitial Lung Disease
VAPs	Volume Assured Pressure Support	**Ht**	Height
OSA	Obstructive Sleep Apnea	**Wt**	Weight

STOP BANG Snoring, Tired, Observed, Pressure, Body Mass Index, Age, Neck Size, Gender

Date (dd/mm/yyyy)	Time (24 hour)	Patient Signature	Designation / College ID #
/ /			

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