# SLEEP ASSESSMENT REQUEST


| | | |
|---|---|---|
| **Saskatoon** | Ph: 306-384-5255 | ***Fax: 306-384-0022*** |
| **Regina** | Ph: 306-545-8883 | ***Fax: 306-545-3284*** |
| **Yorkton** | Ph: 306-828-0355 | ***Fax: 306-828-0357*** |
| **Prince Albert** | Ph: 306-763-0355 | ***Fax: 306-763-0354*** |

**www.prairieoxygen.ca** **Toll Free** 1-877-738-8702


ACCREDITED WITH EXEMPLARY STANDING
ACCREDITATION AGRÉMENT CANADA

☐ **Level III Sleep Apnea Screening**

☐ 1 Night Study

Date of Referral: M M M / D D / Y Y Y Y

☐ **Auto CPAP Titration**

☐ 1 Week Auto Study

Pressure Range _____ to _____
(5cm to 20cm $H^20$ is used unless otherwise specified)

☐ Currently No Cough, Fever or on Antibiotics

## Patient Information

Date of Birth: M M M / D D / Y Y Y Y Height: _____ Weight: _____

Last Name: _____ Patients Address: _____

First Name: _____ _____

Home Phone: _____ Patients PHN#: _____

Other: _____ _____

## Physician to Complete

| | Yes | No |
|---|---|---|
| ***1.** Is the patient over the age of 65 with comorbidities? | ☐ | ☐ |
| **2.** Is the patient frequently working night shifts? | ☐ | ☐ |
| ***3.** Is the patient a commercial driver, airline pilot or train engineer, or work in Emergency services? | ☐ | ☐ |
| ***4.** Is the patient regularly taking sedatives, narcotics antidepressants, sleeping pills or modafinil? | ☐ | ☐ |
| ***5.** Does the patient have chronic atrial fibrillation? | ☐ | ☐ |
| ***6.** Does the patient have uncontrolled CHF? | ☐ | ☐ |
| ***7.** Does the patient have symptomatic chronic respiratory failure? | ☐ | ☐ |
| **8.** Is there a high likelihood of another sleep disorder? | ☐ | ☐ |
| ***9.** Is the patient currently on supplemental oxygen therapy? | ☐ | ☐ |
| **10.** Is the patient a smoker? | ☐ | ☐ |
| **11.** Does the patient live in a home where there is smoking? | ☐ | ☐ |
| **12.** Does the patient / or family have the ability to follow written instructions for connecting and using the testing equipment? | ☐ | ☐ |

** Please note: a "**YES**" answered to any of the questions labeled "*****" indicate that a direct referral be made to the Sleep Disorders Centre, and that portable in home sleep monitoring is not recommended.*

## Physician Information

Requesting Physicians Name: _____ (Please PRINT) Physicians Address: _____

Signature: _____ Physicians Phone Number: _____

**Office Use Only:** Downloaded ☐ Scored ☐ Repeat ☐ Sent ☐

Date Booked _____ Serial #/Unit # _____ Mask _____

Comments: _____