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**

☐ **Level III Sleep Apnea Screening** (one night study)
Date of Referral: M M /D D/Y Y

☐ **Auto CPAP Titration Study** (one week study)
Pressure Range _____to ____
5cm to 20cm H_2O is used unless otherwise stated
☐ Currently no cough, fever or on antibiotics

Patient Information

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

Last Name: _____ First Name: _____

Address: _____

Home Phone: _____ Other (cell/work): _____

PHN: _____ _____ _____

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. Does the patient have chronic atrial fibrillation?	☐	☐
4. Does the patient have uncontrolled CHF?	☐	☐
5. Is the patient regularly taking sedatives, narcotics, antidepressants, sleeping pills or modafinil?	☐	☐
6. Is the patient a commercial driver, airline pilot, train engineer or work in emergency services?	☐	☐
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. Is there smoking in the home?	☐	☐
12. Does the patient/family have the ability to follow written Instructions for connecting and using the testing equipment?	☐	☐

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

Physician/Nurse Practitioner Information

Requesting Physicians/NP Name: _____ **Signature:** _____

Address: _____ **Phone Number:** _____

_____

Signature allows for: Type III Testing
Proceed to Auto Titration Study (when Level III tests positive for OSA (Obstructive Sleep Apnea) by interpreting Respirologist)
Referral to Respirologist on your behalf for consult and/or recommendation
Unless otherwise specified by referring physician:

_____

_____
comments