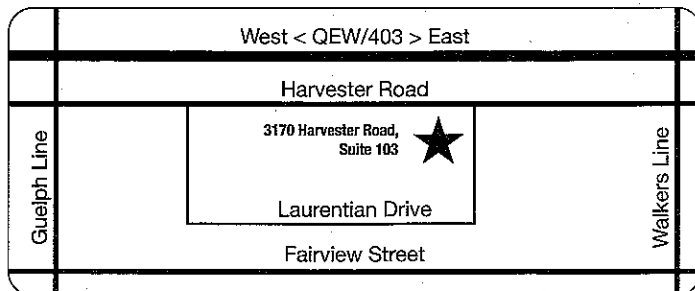


BURLINGTON SLEEP MEDICINE CENTRE

3170 Harvester Road, Suite 103, Burlington, Ontario L7N 3W2 3iv 8
www.sleepawake.com Tel: (905) 338-3331 Lab: (905) 632-9015

PATIENT INFORMATION



In order for us to achieve the best possible results, please read and follow the instructions below:

- **ARRIVE ON TIME**, set up takes approximately one hour and we need to make sure that we get enough of your sleep recorded.
- Remember to bring your **Ontario Health Card**.
- Do not drink any alcoholic beverages for 12 hours prior to the sleep study.
- Do not consume caffeine after 6 p.m. on the night of your sleep study, i.e. coffee, tea, colas, chocolate.
- Bring all your **medications** and take them as usual, unless advised by the doctor.
- **If you are on Nasal CPAP or Oxygen, please bring your equipment with you. CPAP Patients bring mask and hose ONLY.**
- Do not nap the day of your sleep study.
- If you are diabetic, please bring a snack with you as food is not available at the clinic.
- Please bring personal hygiene items to the sleep lab, as well as your nightclothes. You may also bring with you a favourite pillow or something similar to help you sleep.
- You may wish to bring reading material in case of unexpected delays.
- **Leave all valuables at home.** Sleep Medicine Centre cannot assume responsibility for loss of personal possessions.
- In order to obtain the best results, you must have clean skin. **Please make sure that your hair and skin are clean and free of cosmetics, oils, creams or gels on the day of your test.**
- Please refrain from wearing coloured nail polish and also acrylic nails if possible, as it prevents accurate readings from the equipment.
- **PLEASE RING DOOR BELL ON ARRIVAL.**
- If you have any further questions or require further clarification on the instructions, please call us.
- **A MISSED APPOINTMENT FEE OF \$150 WILL BE CHARGED IF 2 WORKING DAYS NOTICE IS NOT GIVEN.**

Study Date: _____

Study Time: _____

Dear _____

Your overnight sleep study has been booked for the above date and time. Please call to confirm your appointment when you receive this letter.

The sleep lab is located at 3170 Harvester Road. The entrance is located on the South side of Harvester.

IMPORTANT: If you need to reschedule or cancel your sleep study, you must give us at least 2 working days notice or a \$150 missed appointment fee will be charged.

FOR YOUR INFORMATION

Your sleep study will be conducted overnight while you sleep. At the clinic, a technologist who will attend to you for the evening will greet you. Electrodes will be attached to the surface of the skin with tape and a small amount of gel to monitor various functions during the night. There is no discomfort and virtually everyone is able to sleep without any difficulty. You will be in a private room and under continuous audio-visual monitoring throughout your stay.

It is necessary for you to bring comfortable clothing to sleep in. You can wear pajamas, nightgown, or shorts and a T-shirt. Just make sure that it is comfortable and that you will be able to sleep in it.

Overnight parking is available immediately beside the clinic. Parking is free.

You will be awakened between 6:00 and 6:30 a.m. in the morning following your test. Finishing your study will take a further 30 minutes. You will be able to leave about 6:30 to 7:00 a.m. If you need to leave earlier, please inform the technologist so that he or she can make adjustments.

PATIENT'S COPY

BURLINGTON SLEEP MEDICINE CENTRE

3170 Harvester Road, Suite 103, Burlington, Ontario L7N 3W8

www.sleepawake.com

Medical Director: Dr. H. Awad, M.D., F.R.C.P.C, M.R.C.Psych. (UK), Dip. A.B.S.M., F.A.A.S.M.

Office: (905) 338-3331 Lab: (905) 632-9015 Fax: (905) 338-2923

SLEEP STUDY REFERRAL

Date of Referral: _____

Referring Doctor: _____

Physician No.: _____

Telephone: _____

Fax No.: _____

Patient Surname: _____

Given Name: _____

Date of Birth (dd/mm/yyyy): _____

Address: _____

Home Telephone: _____

Business Telephone: _____

Health No.: _____

Version Code: _____

PURPOSE OF SLEEP STUDY: Diagnosis Treatment Investigation & Treatment as necessary

COMPLAINTS

- | | |
|--|---|
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Disturbed, Restless Sleep |
| <input type="checkbox"/> Snoring with Apnea | <input type="checkbox"/> Non-Restorative Sleep |
| <input type="checkbox"/> Recurrent Headaches | <input type="checkbox"/> Leg Jerks, Restless Legs |
| <input type="checkbox"/> Daytime Fatigue, Excessive Daytime Sleepiness | <input type="checkbox"/> Sleep Walking, Talking, Violent Behaviour at Night |
| <input type="checkbox"/> Other (Specify): _____ | |

PROVISIONAL DIAGNOSIS

- | | |
|---|---|
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Restless Legs Syndrome | <input type="checkbox"/> Periodic Limb Movements Disorder |
| <input type="checkbox"/> Idiopathic Hypersomnia | <input type="checkbox"/> Narcolepsy |
| <input type="checkbox"/> Other (Specify): _____ | |

MEDICAL & SURGICAL HISTORY: _____

CURRENT MEDICATIONS: _____

SIGNATURE OF REFERRING PHYSICIAN: _____

Scoring, interpretation of the study and clinical evaluation of patients are all completed on site.

Please contact the office at (905) 338-3331 to book appointment or fax this form to (905) 338-2923 and we will be in contact soon.

Please advise patient that there will be two appointments booked for them. Thank you.

