Sleep Disorder Centre INPATIENT STUDY

Misericordia Health Centre
99 Cornish Avenue Winnipeg, Manitoba R3C 1A2
Fax back to: 204-788-8033
Telephone: 204-788-8570

Inpatient referrals require a virtual consultation. Referring physicians call 204-788-8570 on the day of referral to be directed to the Triage Sleep Physician.

Patient Information
Client Surname:
Given Name:
Date of Birth:
Sex:
MFRN:
PHIN:
Addressograph Place Label Here
Full Address:

Treaty #:
RCMP #:
Military #:

Patients must be medically stable prior to consideration/referral for an inpatient sleep study

An incomplete referral/ without virtual consultation will be cancelled and, as a result, will be considered as NOT received.

Inpatient Information

Hospital: ________________ Unit: ___________ Phone #: _________________ ext: ________ Fax #: ________________________

Date of Admission: _____________ Estimated Discharge Date: _________________ Height (cm): ________ Weight(kg): ________ BMI: _______

Allergies:

Isolation Requirements:

Medically Stable? ◯ **Yes** ◯ **No**

Patient Consent for Study? Yes ◯ No
If recommended, will patient accept treatment with CPAP/BIPAP? ◯ Yes ◯ No

Medical History: (Include/attach: reason for admission, admission history, relevant history or recent MD note)

Indication	Tests Required for Indication
◯ Suspected Severe Sleep Apnea	◯ Blood Gas on Room Air or ◯ on O_2 ____lpm (within the last week) ◯ Overnight Oximetry (within the last week) If Available: ◯ Echocardiogram **OR** MIBI **OR** MUGA (if Central Sleep Apnea or Cheyne Stoke Suspected)
◯ Suspected Hypoventilation (new diagnosis, not previously treated): ◯ Obesity Hypoventilation Syndrome (OHS) ◯ Hypoventilation secondary to other medical cause(s): Suspected Cause(s) of Hypoventilation:	◯ Blood Gas on Room Air or ◯ on O_2 ____lpm (within the last week) ◯ Overnight Oximetry (within the last week) ◯ Spirometry (within the last week) If Available: ◯ Pulmonary Function Test ◯ CT Chest
◯ Titration of Positive Airway Pressure Therapy (PAP) (Previous diagnosis of sleep breathing disorder)	◯ Recent Blood Gas: ◯ on Room Air or ◯ on O_2 ____lpm ◯ Overnight oximetry on current PAP treatment (within the last week) ◯ Current Settings/O_2: ________________________________

Activities of Daily Living – Study Support Requirements

Is the patient currently stable to attend outpatient facility overnight? ◯ Yes ◯ No
Currently requires supplemental Oxygen: ◯ Yes ◯ No
Current treatment with CPAP/BiPAP as inpatient ◯ Yes Current Settings/O_2: ____________________________ ◯ No

Patient requires IV, subcutaneous, oral medication administration (cannot self-administer), management of tube feeds: ◯ Yes **(REQUIRES NURSE ESCORT)** ◯ No

Patient Requires Support with Mobility? ◯ Yes **(REQUIRES HEALTH CARE AID ESCORT)** ◯ No
Support Required: ◯ Stand By Assist ◯ 1 Assist ◯ 2 Assist ◯ Mechanical Lift

Ordering Clinician

Date Ordered:

Clinician Signature ______ Clinician Name ______ Billing # ______ Phone # ______