

Name : _____ First name : _____ Birthdate : _____
Address : _____
Insurance n° : 807 _____ Insurance : _____ AVS n° : 756. _____
Phone : _____ Email : _____

- ☐ **Specialised consultation with a somnologist (specialised consultation, scheduling of a polysomnographic exam and/or daytime sleepiness tests, therapeutic proposal)**
- ☐ **Polysomnography (1 night) due to :**
- ☐ Suspicion of sleep apnoea-hypopnoea syndrome
Type : ☐ Standard exam ☐ Exam with capnography
 - ☐ Suspicion of periodic limb movements during sleep
- ☐ **Adult polygraphic examination (1-night ambulatory) due to :**
- ☐ Suspicion of sleep apnea-hypopnea syndrome as part of a preoperative assessment.
- ☐ **Other examination, other request :** _____
- ☐ **Follow-up in cognitive behavioral therapy for insomnia carried out by a psychologist from the Cenas center.**
- Indications :** ☐ Insomnia (CBT-I) (7 sessions) ☐ Circadian rhythm disorders (4-5 sessions)
- ☐ PSG assessment preparation ☐ Sleep-wake rhythm regulation ☐ Sleep hygiene

Clinical information

Sleep disorder: _____

Medical history: _____

Current treatments: _____

Previous treatments: _____

Limited independence (motor, cognitive, or other impairments): ☐ Yes ☐ No

If yes, please specify: _____

Weight/Height : _____ BMI : _____

Referring physician : _____ Stamp : _____

Date : _____