

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 preparati_____ 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 : _____