West Ottawa Sleep Centre

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ALL INFORMATION MUST BE COMPLETE TO ALLOW US TO BOOK THIS REFERRAL – THANK YOU

PATIENT INFORMATION

Last Name: ______________________ **First Name:** ______________________

Street Address: ________________________________ **Apt/Unit No.** __________

City: ________________ **Province:** ____________ **Postal Code:** __________

OHIP # ______________________ **Version Code:** ______ **Expiry Date:** __________

Telephone Number (including Area Code) ________________________________

Email address: ____

Date of Birth (MM/DD/YYYY) __________________ **Male** _____ **Female** _____ **Other** _____

REASON FOR REFERRAL (*Please mark all that apply):*

- □ **Snoring / Sleep Apnea**
- □ **Excessive Daytime Sleepiness**
- □ **Insomnia**
- □ **Limb Movements (Period Limb Movements/Restless Legs)**
- □ **Parasomnias (Sleep Walking, Sleep Talking, etc.)**
- □ **Other (Please specify)** ______________________________

CARE REQUESTED:

- □ **Routine Protocol – includes consultation and/or sleep-related investigations, if indicated**
- □ **Sleep Consultation Only**
- □ **Baseline Nocturnal Sleep Study Only**
- □ **Treatment Sleep Study Only**

PATIENT CONSIDERATIONS (*Please mark/provide all that apply)* :

Previous Sleep Studies (date/institution) ________________________________

Patient Characteristics: Weight over 400 lbs? □ **Yes** □ **No**

Current CPAP pressure (if applicable) ________________

Medication List – please provide

Auxiliary Aids:
- □ **Oxygen (L/min)**
- □ **Wheelchair**
- □ **Walker**
- □ **Cane**

Other Requirements:
- □ **Translator**
- □ **Companion / Personal Aide**

REQUESTING PHYSICIAN SIGNATURE: ________________________________

PHYSICIAN ADDRESS: ____

PHYSICIAN NAME: ______________________ **BILLING NO.** ______________

OFFICE TELEPHONE NO.: ________________ **FAX NO.** ________________

WOSC-CL-001 MAR21