West Ottawa Sleep Centre

303 – 770 Broadview Avenue, Ottawa, Ont., K2A 3Z3
Tel: 613-722-9900 Fax: 613-722-9100

PEDIATRIC REFERAL FOR (AGES 7-17)

Patient Information*:*

Name (last name, first name): _____

OHIP #:_____ **Gender**: □ Female □ Male

Address:_____ **DOB**:_____ **AGE**: _____

Parent/Gardian's name and contact information_____

Requesting Physician please print _____

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 investigation(s)if indicated)***
□ Sleep Consultation Only
□ Baseline Nocturnal Sleep Study Only ***
□ Treatment Sleep Study Only ***

Patient Considerations and Pre-existing Medical conditions:

□ Behavioral ADD/ADHD
□ Neuromuscular disease
□ Neurological disorder
□ wheelchair/walker
□ Oxygen/cpap/cpap dependent
□ obesity
□ Asthma/Chronic O2,
□ O2
□ Genetic syndrome/Craniofacial anomalies
□ lung disease
□ Cardiac disease
□ other_____

Weight _____ Height _____

Previous Sleep Studies: □ no □ yes date/institution:
Medication list:_____

Requesting Physician Signature and Billing Number _____

Requesting physician's fax number for results_____

******A PARENT/GUARDIAN IS REQUIRED TO STAY FOR THE NIGHT OF THE STUDY***