

West Ottawa Sleep Centre

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Patient Information:

Name: _____

OHIP #: _____

Address: _____

Telephone Number: _____

DOB: _____

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:

Previous Sleep Studies:

- date/institution:

Patient Characteristics:

Weight over 400 lbs? Yes No

Current CPAP pressure (if applicable):

Medication List:

Auxiliary Aids:

- Oxygen (L/min)
- Wheelchair
- Walker
- Cane

Requesting Physician Signature and Billing Number _____