West Ottawa Sleep Centre

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Patient Information:

Name: _____ **OHIP #:** _____

Address: _____ **Telephone Number:** _____

DOB: _____ **Email:** _____

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): _____

Level of Urgency:

- ☐ Routine
- ☐ Urgent (Within 1-3 months).

  Mandatory to specify reason if request is urgent: _____

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
- ☐ Home Sleep Apnea Test (not covered by OHIP)

Patient Considerations:

Previous Sleep Studies:

- ☐ Date/ Institution:
  Please provide copy of previous sleep studies.

Auxiliary Aids:

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

Patient Characteristics:

Weight over 400 lbs? ☐ Yes ☐ No

Medical Condition(s):

Medication List:

Requesting Physician Name (please print): _____

Signature: _____

Billing Number: _____

Last updated: December 2019