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:

Current CPAP pressure (if applicable):

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

Patient Characteristics:
Weight over 400 lbs? ❑Yes ❑No

Medication List:

Requesting Physician Signature and Billing Number : _____