WEST OTTAWA SLEEP CENTRE

MedSleep

West Ottawa Sleep Centre
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SLEEP DISORDER REFERRAL FORM *PLEASE FAX THIS FORM TO: 613-722-9100*

PERSONAL INFORMATION

Name _____ Preferred Contact Phone _____

OHIP # _____ VC _____ Street Address _____

Birth Date _____ Age _____ City _____ Postal Code _____

Height _____ Weight _____ Gender: ☐ M ☐ F Email _____

REFERRING PRACTITIONER

Physician/NP _____ Street Address _____

Billing # _____ City _____ Postal Code _____

PLEASE CHECK applicable practice model so you will not be negated: Phone _____ Fax _____

▶ ☐ **FHT** ☐ **FHO** ☐ **FHG** ☐ **FHN** ☐ **FFS** ☐ **HSO** Email _____

REFERRAL FOR

☐ **SLEEP STUDY ONLY** (*Please complete sections 1–5 below*) *OR* ☐ **CONSULTATION AND SLEEP STUDY, IF INDICATED** (*Please complete sections 1–3 below*)

- *Has the referred patient had a previous sleep study?* ☐ *Yes* ☐ *No*
- *If yes, please provide the date of the last sleep study:* _____ *Location:* _____
- *Please provide the most recent sleep study report if it was done at another facility*

HISTORY AND PHYSICAL INFORMATION

_____

_____

_____

☐ **ELECTIVE** ☐ **URGENT** If urgent, please explain: _____

_____

❶ STORY OF SLEEP PROBLEM

☐ Snoring ☐ Nocturia ☐ Restless Legs Syndrome ☐ Cataplexy

☐ Witnessed Apneas ☐ Insomnia ☐ Periodic Limb Movement Disorder ☐ Sleepwalking/Nightmares

☐ Excessive Daytime Sleepiness ☐ Frequent Awakenings ☐ Shift Work ☐ Other _____

❷ MEDICAL CONDITIONS

☐ MI/CAD ☐ Seizures/Epilepsy ☐ GERD ☐ Fibromyalgia ☐ Mood Disorder ☐ Anxiety Disorder ☐ Hypertension

☐ Diabetes ☐ Stroke ☐ Asthma/COPD ☐ Chronic Pain ☐ CHF ☐ Cardiac Arrhythmia

❸ MEDICATIONS

_____

_____

❹ DOES THE PATIENT HAVE A SAFETY CRITICAL OCCUPATION?

☐ Yes ☐ No

❺ SPECIAL NEEDS *(i.e., assistance moving, difficulty communicating)*

_____

Physician/NP signature: _____ Date: _____

☐ *PLEASE CHECK IF YOU WOULD LIKE US TO SEND YOU MORE REFERRAL FORMS.*