SOMNOCARE
SLEEP & LIFESTYLE MEDICINE

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☐ **URGENT (< 1 month)** ☐ **NON-URGENT (> 1 month)**

PATIENT INFORMATION

Name: _____

Full Address: _____

OHIP: _____ Version Code: _____

Date of Birth: _____ Pronoun: ☐ He/Him ☐ She/Her ☐ They/Them

Preferred Phone: _____

Email: _____

Safety-Critical Occupation? (if yes, please specify): _____

REFERRING PRACTITIONER INFORMATION

Name: _____

Billing Number: _____ CPSO Number: _____

Phone: _____ Fax: _____

FAMILY PHYSICIAN (if different)

Name: _____ Fax: _____

REASON FOR REFERRAL:

☐ Snoring / Sleep Apnea
☐ Excessive Daytime Sleepiness
☐ Nocturnal Bruxism / Abnormal Behaviours
☐ Frequent Awakenings
☐ Other: _____

REFFERAL REQUEST:

☐ Sleep Medicine Consult (OHIP)
- ☐ Rapid A/B/C/VPAP Renewal (no ADP grant)
- ☐ Previous PSG? (if so, attach report)

☐ In-Home Sleep Study (+ OHIP consult)
- ☐ Level 2 (not covered by OHIP)
- ☐ Level 3 (not covered by OHIP)

PLEASE ATTACH CURRENT PATIENT PROFILE WITH MEDICAL HISTORY & MEDICATIONS