# SOMNOCARE
SLEEP & LIFESTYLE MEDICINE

Unit 103 - 5420 Canotek Road
Gloucester, ON, K1J 8X5
Tel: (613) 695-6577
Fax: (888) 676-4868
inquiries@somnocare.ca

☐ **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: _____

**REFERRAL REQUEST:**

- ☐ Sleep/Circadian Medicine Consult (OHIP)
- ☐ Sleep/Circadian Medicine Consult (Non-OHIP)
  - ☐ Previous Sleep Study? (if so, attach report)
- ☐ In-Home Sleep Study FIRST (Non-OHIP)
  - ☐ Level 2 ➡️ Consult if indicated? ☐
  - ☐ Level 3 ➡️ Consult if indicated? ☐

**REASON FOR REFERRAL:**

- ☐ Snoring / Sleep Apnea
- ☐ Frequent Awakenings / Insomnia
- ☐ Excessive Daytime Sleepiness
- ☐ Nocturnal Teeth Grinding / Clenching
- ☐ Assess Candidacy for In-Home Sleep Study
- ☐ Rapid A/B/C/VPAP Renewal (no ADP Grant)
- ☐ Other: _____

**PLEASE ATTACH CURRENT PATIENT PROFILE WITH MEDICAL HISTORY & MEDICATIONS**