SOMNOCARE
SLEEP & LIFESTYLE MEDICINE

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inquiries@somnocare.ca

DATE: _____ ☐ **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

www.somnocare.ca