

PATIENT INFORMATION

Name _____ Home Phone _____ DOB _____
 Street Address _____ Work/Cell Phone _____ M/F _____
 City, State, Zip _____ Email Address _____
 Insurance _____ ID# _____ Subscriber _____

PATIENT IS BEING REFERRED FOR (check only ONE from this section)

Sleep Study, Evaluation and Treatment

- Consultation and Management**
→ Visit with a sleep specialist to evaluate and treat patient.
- Sleep Study and Treatment**
→ Includes sleep study (split night sleep study – first part diagnostic, second part CPAP titration if criteria met), post study consult and PAP therapy initiation (if indicated).
- Home Sleep Study and Treatment (adult only)**
→ Includes sleep study, post study consult and PAP therapy initiation (if indicated). Patient has high probability of moderate-to-severe OSA and no significant co-morbid medical conditions or sleep disorders (appropriate insurance coverage required).

Therapy Only

- CPAP Therapy Program**
→ Visit with a CPAP therapist for evaluation and training, initiation of therapy, mask fitting, compliance management or equipment assessment.
- Oral Appliance Evaluation and Treatment**
→ Evaluation and fabrication (as appropriate) of oral appliance to treat snoring or sleep apnea.

Sleep Study Only (Results sent to referring physician for further management.)

- Diagnostic Sleep Study**
→ Full night polysomnography (PSG).
- Split Night Sleep Study**
→ Full night sleep study. First part diagnostic, second part CPAP titration if criteria met.
- CPAP or Bi-level PAP Titration (circle one)**
→ Full night titration for patients with documented sleep apnea.
- Sleep Study with Full EEG (where available)**
→ Overnight video-EEG monitoring with PSG to evaluate for nocturnal seizures, other causes of sleep disruption, or cognitive dysfunction.
- Diagnostic Sleep Study and Multiple Sleep Latency Test (MSLT)**
→ Daytime nap test following a full night diagnostic PSG study to diagnose narcolepsy or excessive sleepiness.
- Home Sleep Study (adult only)**
→ Patient has high probability of moderate-to-severe OSA and no significant co-morbid medical conditions or sleep disorders (appropriate insurance coverage required).

MEDICAL HISTORY (a recent history and physical examination is required)

Suspected Disorder(s)

- Obstructive sleep apnea (OSA)
- Narcolepsy
- Nocturnal seizures/parasomnias
- Insomnia
- Restless legs syndrome (RLS) or periodic limb movements of sleep (PLMS)

Primary Symptoms

- Snoring/gasping/choking
- Witnessed apneas
- Obese/large neck
- Daytime sleepiness
- Difficulty falling asleep
- Fragmented sleep
- Frequent leg movements during sleep

Special Needs

- Nocturnal O2 (level: _____)
- Interpreter (language: _____)
- Wheelchair
- Currently using PAP (pressure: _____ cm)
- Other _____

Medications and/or comments: _____


PHYSICIAN INFORMATION

Referring Physician

Name _____
 Street Address _____
 City, State, Zip _____
 Phone _____
 Fax _____
 Email Address _____

Primary Care Physician Same as Referring Physician Yes No

Name _____
 Street Address _____
 City, State, Zip _____
 Phone _____
 Fax _____
 Email Address _____

 **Physician's Signature** _____ **Date** _____