

Please fill out this form completely and fax along with patient's History & Physical and insurance cards.

SECTION 1 - PATIENT INFORMATION

Name: _____
 SSN: _____ DOB: _____
 Home Phone: _____ Cell Phone: _____
 Work Phone: _____
 Height: _____ Weight: _____

SECTION 2 – CLINICAL OBSERVATIONS AND PHYSICAL FINDINGS

Presenting Symptoms & Physical Findings *Diagnosis Code:* _____

- | | | |
|---|---|--|
| <input type="checkbox"/> Observed Apnea | <input type="checkbox"/> Non-Restorative Sleep | <input type="checkbox"/> Enlarged Neck Circumference |
| <input type="checkbox"/> Awakens gasping for breath | <input type="checkbox"/> Creeping/Crawling Legs | <input type="checkbox"/> Enlarged Tongue |
| <input type="checkbox"/> Morning Headaches | <input type="checkbox"/> Leg Restlessness/Jerks | <input type="checkbox"/> Worn Teeth |
| <input type="checkbox"/> Sleep Walking | <input type="checkbox"/> Excessive Somnolence | <input type="checkbox"/> Enlarged Tonsils |
| <input type="checkbox"/> Frequent Awakenings | <input type="checkbox"/> Seizures | <input type="checkbox"/> Maxillomandibular Abnormalities |
| <input type="checkbox"/> Loud Snoring | <input type="checkbox"/> Syncope | <input type="checkbox"/> Crowded Oropharynx |
| <input type="checkbox"/> Pathological 'Sleep Attacks' | <input type="checkbox"/> Impaired Cognition | <input type="checkbox"/> Mood Disorders |
| <input type="checkbox"/> Other: _____ | | |

MEDICAL HISTORY

- | | | | | |
|---------------------------------|-----------------------------------|---------------------------------------|---|---|
| <input type="checkbox"/> CHF | <input type="checkbox"/> Obesity | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Cardiac Arrhythmias |
| <input type="checkbox"/> COPD | <input type="checkbox"/> CVA | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Dementia | <input type="checkbox"/> Ischemic Heart Disease |
| <input type="checkbox"/> OSA | <input type="checkbox"/> GERD | <input type="checkbox"/> Depression | <input type="checkbox"/> Stroke | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Mental Retardation | <input type="checkbox"/> Connective Tissue Disorder |

SECTION 3 - STUDY ORDER INFORMATION

COMPLETE SLEEP REFERRAL

Patient seen by sleep physician with all appropriate testing done and equipment set up, if needed.

- | | |
|--|--|
| <input type="checkbox"/> Baseline PSG | <input type="checkbox"/> MWT |
| <input type="checkbox"/> All Night PAP Titration (CPAP/Bilevel PAP) | <input type="checkbox"/> ETCO2 Monitoring |
| <input type="checkbox"/> Split Night (PAP initiated if severe to mod. OSA) | <input type="checkbox"/> Standard EEG |
| <input type="checkbox"/> Auto SV PAP Titration | <input type="checkbox"/> Sleep Deprived EEG |
| <input type="checkbox"/> Narcolepsy study (<i>Baseline PSG with next day MSLT</i>) | <input type="checkbox"/> Ambulatory EEG: 24 or 48 hour (circle choice) |

SECTION 4 – INTERPRETING PHYSICIAN (ALL BOARD CERTIFIED IN SLEEP MEDICINE)

- | | |
|--|--|
| <input type="checkbox"/> Dr. David Henson, Medical Director (Sleep, adult) | <input type="checkbox"/> Dr. James Davis, Sleep Center Staff (Adult/Pediatric) |
| <input type="checkbox"/> Dr. Daniel Donovan (EEG/Sleep, adult/pediatric) | <input type="checkbox"/> Dr. Vijay Rupan (Sleep, adult) |
| <input type="checkbox"/> No Preference | |

APPT. DATE:

PRE CERT. #:

Signature: _____ Date: _____

Print Physician Name: _____

Phone #: _____ FAX #: _____