

Sleep Medicine Referral Form

FAX: 203 909-6953

QUESTIONS: 203 909-6950

PATIENT INFORMATION

Name: _____ DOB: _____ SS#: _____ Date: _____
 Street Address _____ City _____ State _____ Zip _____
 Phone(H) () _____ (W) () _____ Cell () _____
 Primary _____ ID No _____ Authorization No _____
 Secondary _____ ID No _____ Authorization No _____

PLEASE ATTACH COPY OF PATIENT'S INSURANCE CARD (FRONT & BACK) & PREAUTHORIZATION AS NEEDED

Reason for Referral: Please include working diagnosis, pertinent physical and psychiatric findings:

SLEEP SERVICES

- COMPREHENSIVE SLEEP CONSULT** (sleep physician evaluation, testing as needed, treatment and follow-up)
- SLEEP STUDY TESTING ONLY** (if medical information insufficient to support need for sleep testing or if patient under 18 years of age, a sleep consult will be scheduled)
 - Diagnostic Sleep Study (Split study if meets criteria)
 - Daytime CPAP Management
 - Daytime Sleep Testing
 - CPAP (Re)Titration
 - Other _____
 - Follow-up Visit

MEDICAL HISTORY (PLEASE INCLUDE RECENT OFFICE NOTES AND H&P)

Sleep Complaints

- Snoring
- Witnessed apnea
- Excessive daytime sleepiness
- Insomnia
- Restless Legs
- Sleepwalking/talking/eating
- Cataplexy
- Other _____

Current Diagnoses

- OSA
- Hypertension
- GERD
- Asthma/COPD
- Anxiety/depression
- Coronary Artery Disease
- Osteoarthritis
- Other _____

Special Needs

- Wheelchair
- Interpreter
- Out of bed with assist
- Commode
- Assistance with ADL
- Tracheotomy
- Other _____
- None

Is patient currently on CPAP? NO YES CPAP Pressure _____ cmH₂O
 Is patient currently on oxygen NO YES @ _____ liters/min
 Has patient had prior sleep studies NO YES Where _____ When _____
 Has patient had ENT evaluation NO YES

Current Medications: _____

REFERRING PHYSICIAN INFORMATION

Name: _____ Tel () _____ Fax () _____
 Address: _____ City _____ State _____ Zip _____
 Signature: _____