Sleep Associates of Connecticut
the sound sleep center

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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) ❑ CPAP (Re)Titration ❑ Follow-up Visit
❑ Daytime CPAP Management ❑ Daytime Sleep Testing ❑ Other_____

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

Sleep Complaints	Current Diagnoses		Special Needs
❑Snoring	❑OSA	❑Obesity	❑Wheelchair
❑Witnessed apnea	❑Hypertension	❑Stroke	❑Interpreter
❑Excessive daytime sleepiness	❑ GERD	❑Diabetes	❑Out of bed with assist
❑ Insomnia	❑Asthma/COPD	❑Rhinitis	❑Commode
❑ Restless Legs	❑Anxiety/depression	❑Fibromyalgia	❑Assistance with ADL
❑ Sleepwalking/talking/eating	❑Coronary Artery Disease	❑Hypothyroidism	❑Tracheotomy
❑Cataplexy	❑Osteoarthritis	❑CHF	❑Other_____
❑Other_____	❑Other_____	❑None	❑None

Is patient currently on CPAP?	❑NO	❑YES	CPAP Pressure _____ cmH_2O
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: _____