

**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 \_\_\_\_\_ cmH<sub>2</sub>O  
 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: \_\_\_\_\_