**DIRECT REFERRAL FOR SLEEP STUDY**

Please complete this form and submit for review a current history and physical for the patient. After review of the information and approval of the requested sleep study by our sleep staff physician, the patient will be contacted to schedule a sleep study.

**Patient Personal Information:**

Name: Date of Birth:

Home Phone: Cell or Work Phone: (c) (w)

**Demographics:**

Gender: M / F Age: Height: Weight:

Sleeping Hours: From: To: □ Night □ Day □ Evening

Occupation:

**Physician Information:**

Requesting Physician: Phone: Fax:

Primary Care Physician: Phone: Fax:

**History and Physical Information**

**History of Sleep Problem:**

|  |  |  |
| --- | --- | --- |
|  | □ Excessive Daytime Sleepiness | □ Shift Work |
|  | □ Morning Headaches | □ Cataplexy |
|  | □ Snoring | □ Nocturia |
|  | □ Witnessed Apneas | □ Sleep Paralysis |
|  | □ Claustrophobia | □ Insomnia |
|  | □ Frequent Awakenings | □ Sleep Walking |
|  |  |  |

**Medical Conditions:**

|  |  |  |
| --- | --- | --- |
|  | □ Cardiac Arrhythmias | □ GERD |
|  | □ CHF | □ Diabetes |
|  | □ ALS | □ Asthma/COPD |
|  | □ Stroke/Weakness | □ Chronic Pain |
|  | □ Seizures | □ Fibromyalgia |

**DIRECT REFERRAL FOR SLEEP STUDY cont.**

**Social History & Family History**

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Physical Examination HEENT**

Nasopharynx:

Oropharynx:

Jaw/Mouth:

Tongue:

Dentition/Mucosa:

Neck:

Heart/Lungs:

Neurologic Exam:

**Reason(s)/Study Types**

**Type** □Standard □MSLT/MWT

□CPAP/BiPAP Titration □Seizure Protocol

□Split-Night (if indicated) □Other

**Diagnosis and Special Needs**

**Diagnosis:**

□ Obstructive Sleep Apnea □ Narcolepsy □ Seizures

□ PLMD/Restless Legs □ Hypersomnia □ ALS

□ Sleepwalking/RBD □ Shiftwork □ Insomnia

**Special Needs:**

□ Oxygen □ Assistance Moving □ Wheelchair

□ Difficulty □ Medications □ Other

Communicating

Ordering Physician Signature: Date:

Approval by facility director/designated sleep staff physician:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_