Physician Referral Form

Please fax to (949) 364-5879

Phone (949) 364-1236

Patient's Name:_______________________ DOB:_______________ Male / Female

Home Phone ( ) _______________ Work ( ) _______________ Cell ( ) _______________

Weight_______________ Height_______________ (estimation OK)

***Please forward a copy of the patient's insurance card for pre-authorization.**

Examination Requested:

_____ Sleep study with CPAP titration (if meets clinical criteria)
_____ Sleep study only (NPSG) with dental device
_____ CPAP titration (documented OSA by NPSG)
_____ Sleep study with MSLT next day (if no cause found for sleepiness, i.e.: suspected Narcolepsy)
_____ Consultation by Sleep Specialist
_____ Overnight diagnostic Apnea Link (Unattended home sleep apnea screening device, with an overnight pulse oximetry)
_____ Overnight Pulse Oximetry

Clinical Information:

_____ Excessive daytime sleepiness or fatigue
_____ Snoring
_____ Witnessed apnea
_____ Nocturnal leg movements or twitching
_____ Sleepwalking
_____ Violent or unusual sleep behavior
_____ Insomnia associated with above features
_____ Other _______________________

Pediatric patients:

_____ EDS or fatigue
_____ Agitation or irritability
_____ Impaired learning, development
_____ Snoring/apnea
_____ Enlarged tonsils/adenoids
_____ Breathing abnormalities

Associated Diagnoses:

_____ Obesity
_____ COPD
_____ CHF
_____ HTN
_____ Arrhythmia
_____ Cognitive Impairment
_____ Other medical conditions_______________

Medications:

_____ Sedatives/hypnotics
_____ Stimulants
_____ Psychiatric meds

*Some medications must be held prior to testing

*Include previous Polysomnograms

***Please include any pertinent chart notes, H&P or consultation reports (AASM Requirement)**

Referring Physician: _______________________ **Date:**_______________

Phone number ( ) _______________________ **Fax# ( )** _______________________

Sleep Disorders Institute

PHYSICIAN REFERRAL FORM

Pt. Name:

SC-1727 (2/22)