



Date: _____

Phone (866)511-5678

Fax (866) 850-5193

- 7150 N President George Bush Highway
- 2046 Forest Lane
- 1611 N Belt Line Road

- Suite 205
- Suite 110
- Suite C

- Garland, Texas
- Garland, Texas
- Mesquite, Texas

- 75044
- 75042
- 75149

Sleep Referral Form

Patient Information

Patient Name: _____
 Address: _____
 City & Zip: _____ State _____
 Cell #: _____
 Home #: _____
 Work #: _____
 SSN: _____ DOB: _____

Insurance Information

Carrier: _____
 Telephone: _____
 Group No.: _____
 ID No: _____
 Person Insured: _____
 Insured SSN: _____
 Insured DOB: _____

Clinical Observations:

<input type="checkbox"/> Heavy Snoring	<input type="checkbox"/> Short Temper/Irritability	<input type="checkbox"/> Obesity
<input type="checkbox"/> Witness Apneas	<input type="checkbox"/> Trouble concentrating	<input type="checkbox"/> Crowded Hypopharynx
<input type="checkbox"/> Snore Arousals	<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Enlarged Neck Circumference
<input type="checkbox"/> Daytime Drowsiness	<input type="checkbox"/> Frequent Napping	<input type="checkbox"/> Enlarged Tonsils
<input type="checkbox"/> Morning Headaches	<input type="checkbox"/> Anxiety/Depression	<input type="checkbox"/> Turbinate Hypertrophy
<input type="checkbox"/> Loss of Energy/Fatigue	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Septal Deviation
<input type="checkbox"/> Restless Sleep	<input type="checkbox"/> Enlarged Tongue	<input type="checkbox"/> Retrognathia
The patient has been diagnosed with obstructive sleep apnea <i>mild</i> <i>mod</i> <i>severe</i> AHI: REM: supine: Date of Diagnosis: ____ / ____ / ____		

Study Ordered (polysomnography):

Evaluate and Perform Sleep Studies (if required)		
<input type="checkbox"/> PSG and CPAP (2 night protocol)	<input type="checkbox"/> Titration study with BiPAP	<input type="checkbox"/> Multiple Sleep Latency Test (MSLT)
<input type="checkbox"/> Diagnostic PSG only	<input type="checkbox"/> Split Night Study with CPAP	<input type="checkbox"/> Maintenance of Wakefulness Test (MWT)
<input type="checkbox"/> Titration study with CPAP	<input type="checkbox"/> Split Night Study with BiPAP	
Special Instructions		
OXYGEN <input type="checkbox"/> Yes <input type="checkbox"/> No	Liters per Minute: _____	
Wheelchair <input type="checkbox"/> Yes <input type="checkbox"/> No	Assistance Moving <input type="checkbox"/> Yes <input type="checkbox"/> No	Translator <input type="checkbox"/> Yes <input type="checkbox"/> No
Medication <input type="checkbox"/> Yes <input type="checkbox"/> No	give: _____	Other orders: _____

I authorize Sleep Trends Diagnostic Centers to perform sleep studies on the above patient according to their protocol, including the urgent initiation of CPAP and oxygen, should it be necessary.

I do not request Sleep Trends to provide sleep follow up, as I will provide the long term care for this patient.

Primary Care Physician: _____

Ordering Physician (if different from above): _____

Address: _____ Telephone: _____
 (Street) (City) (State) (Zip) Fax: _____

Physician Signature (Required): _____ **Date:** _____