Date: _____

SLEEPTRENDS™ DIAGNOSTIC CENTERS

Phone (866)511-5678 Fax (866) 850-5193

□	**7150 N President George Bush Highway**	**Suite 205**	**Garland, Texas**	**75044**
□	**2046 Forest Lane**	**Suite 110**	**Garland, Texas**	**75042**
□	**1611 N Belt Line Road**	**Suite C**	**Mesquite, Texas**	**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:

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

Study Ordered (polysomnography):

	Evaluate and Perform Sleep Studies (if required)				
	PSG and CPAP (2 night protocol)		Titration study with **BiPAP**		Multiple Sleep Latency Test (**MSLT**)
	Diagnostic PSG only		Split Night Study with **CPAP**		Maintenance of Wakefulness Test (**MWT**)
	Titration study with CPAP		Split Night Study with **BiPAP**		

Special Instructions

OXYGEN ❒ **Yes** ❒ **No** Liters per Minute:

Wheelchair ❒ Yes ❒ No Assistance Moving ❒ Yes ❒ No Translator ❒ Yes ❒ No

Medication ❒ Yes ❒ 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:*** _____