Sleep Care Solutions, Inc.
your sleep dream team
www.sleepcaresolutions.com

SLEEP STUDY REFERRAL FORM

Phone: 877-316-7748
Fax: 877.316.7749
Orlando Fax: 407-249-1005
Miami Fax: 305-666-8801

Date: _____ **RE: Patient Name:** _____

DOB: _____ **Patient Phone:** _____

* * * ***Please include patient demographics with insurance information (card front and back) and office notes pertaining to sleep evaluation*** * * *

A. Sleep Evaluation. Which of the following symptoms were noted on the patient's sleep history?

- ❍ Snoring
- ❍ Choking / gasping during sleep
- ❍ Daytime sleepiness
- ❍ Morning headaches
- ❍ Observed apneas
- ❍ Other: _____

(Please Circle One)

Grade 1

Grade 2

Grade 3

Grade 4

B. Focused Physical Examination (include as much information as possible).

Body Mass Index _____ (or height _____ and weight _____)

Neck Circumference _____ inches (or _____ cm)

Upper Airway Evaluation _____

Cardiopulmonary Evaluation _____

Do you have high blood pressure?	yes	no
Do you ever wake with leg cramps or sore extremities?	yes	no
Do you know if, or has someone told you that you kick, twitch or thrash about during sleep?	yes	no
Do you ever have palpitations or rapid thumping or pains in your chest?	yes	no
Do you ever feel short of breath, light headed, or more exhausted than you should while at rest or with excercise?	yes	no

Epworth Scale

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing,
2 = moderate chance of dozing
3 = high chance of dozing

Situation	Chance of Dozing (0-3)
1. Sitting and reading?	
2. Watching television?	
3. Sitting inactive?	
4. As a passenger in a car for an hour without a break?	
5. Lying down to rest in the afternoon?	
6. Sitting and talking to someone?	
7. Sitting quietly after lunch (when you've had no alcohol)?	
8. In a car, while stopped in traffic?	
Epworth Score Total	

Diagnosis:
- ☐ OSA 327.23
- ☐ Narcolepsy 347.00
- ☐ Insomnia 780.52
- ☐ Other Code: _____
- ☐ Baseline PSG Study 95810
- ☐ Post Op / Restudy 95810
- ☐ Split Study 95811
- ☐ CPAP Titration 95811
- ☐ BiLevel Titration 95811
- ☐ MSLT (non nocturnal study) 95805

Other Instructions: _____

_____

Prescriber Signature: _____ Print Name: _____

Address: _____