# SLEEP INSIGHTS SLEEP REFERRAL FORM

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**Please fax patient information to (585) 335.4290:**

**1.) Clinical notes** **3.) Insurance card**
**2.) Medication list** **4.) Demographic sheet**

Last name First name MI

Phone DOB Sex: M F

___ **SLEEP EVALUATION AND MANAGEMENT REFERRAL**
Patient seen for evaluation, indicated sleep studies, treatment management (e.g. CPAP / oral appliance) and any necessary follow up

___ **TESTING *ONLY* — no sleep medicine clinic evaluation**

___ Home Sleep Apnea Test (HSAT) ___ Nocturnal Polysomnogram (PSG) ___ CPAP titration
___ Mean Sleep Latency (MSLT) ___ Maintenance of Wakefulness Test (MWT)

**Clinical Symptoms:** ___ Mood disorders ___ Insomnia ___ Excessive daytime sleepiness
___ Loud Snoring ___ Restless legs ___ Morning headaches
___ Witnessed apneas ___ Hypertension ___ Frequent nocturnal urination (nocturia)

**Sleep Symptoms:** ___ Diabetes E08.4 ___ Obesity (BMI>30) E66.9 ___ Upper airway abnormalities J44.9
___ CAD I25.1 ___ CHF I50.9 ___ Arrhythmia I49.9 /Atrial Fibrillation I48.91
___ Hypertension I10 ___ Stroke I63.30 / TIA G45.9 ___ Neuromuscular disease G71.0

**Fill out Epworth Sleepiness Scale *if requesting testing only***

**How likely are you to doze off or fall asleep in the following situations, compared to just feeling tired?**

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

| SITUATION | CHANCE OF DOZING | SITUATION | CHANCE OF DOZING |
|---|---|---|---|
| Sitting and reading | | Watching TV | |
| Sitting, inactive, in a public place | | As a passenger in a car for an hour | |
| Sitting and talking to someone | | Lying down in the afternoon | |
| Sitting quietly after lunch without alcohol | | In a car, while stopped for a few minutes in traffic | |

**TOTAL SCORE:** _____ 1–10 Normal Range 10–12 Borderline 12–24 Abnormal

Practitioner's signature _____ Date _____

Practitioner's name (PRINT) _____ NPI #_____

Practice name _____ **Dental Practice Y N**