# SLEEP REFERRAL FORM

Southtowns Pulmonary and Sleep Medicine

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**Please fax to (716) 649-5300: 1.) Patient's insurance card**
**2.) Patient's demographic sheet**
**3.) Medication list / Relevant clinical notes**

| Last Name | First | MI |
|---|---|---|
| Phone | D.O.B. | Sex M F |

## OPTION 1: COMPREHENSIVE REFERRAL

☐ Patient to be seen for all suspected obstructive sleep apnea comprehensive care. This includes:
- Evaluation, necessary testing, CPAP titration, CPAP equipment, and followup
- Split-night study (if possible) if testing is done in-lab

## OPTION 2: CUSTOMIZED REFERRAL

### Type of Sleep Study

___ Polysomnogram (PSG) ___ CPAP Titration Study ___ Split-Night Study

___ Home Sleep Testing (only tests for breathing disorders; no sleep analysis is done)

### Customized Involvement

Y N Do you want a sleep consultation or follow up for your patient to assess compliance and efficacy?
Y N Do you want us to schedule the CPAP titration if indicated?
Y N Do you want us to arrange the CPAP equipment if indicated?
Y N We will send your patient to a preferred DME company if you have one _____

### Reason for referral/Comments:

Practitioner's Signature _____ Date _____

Practitioner's Name (print) _____ Phone _____

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