SLEEP INSIGHTS SLEEP REFERRAL FORM

Kenneth Halliwell, MD, Medical Director
Board certified in Neurology and Sleep Medicine
2625 Delaware Avenue | Buffalo, NY 14216 | p (716) 332.0404 | f (716) 871.1998
7220 Porter Rd | Niagara Falls, NY 14304 | p (716) 575.0075 | f (716) 242.0611
SleepInsights.com

Last name First name MI

Phone DOB Sex: M F

SELECT ONE: CONSULTATION OR TESTING

___ **CONSULTATION:** *Patient is seen for evaluation, any indicated sleep studies, CPAP titration/equipment, and follow up.*

TESTING

___ Home Sleep Apnea Testing (HSAT) (CPT 95806)

___ PSG (polysomnogram) overnight sleep test (CPT 95810)

___ CPAP titration (CPT 95811)

___ Other:

If chart notes don't qualify patient for sleep testing coverage, we'll schedule patient for evaluation and order any indicated testing.

FILL OUT BELOW ONLY IF REQUESTING TESTING. DO NOT FILL OUT IF REQUESTING CONSULT.

EPWORTH SLEEPINESS SCALE

SITUATION				
Sitting and reading	0	1	2	3
Sitting, inactive, in a public place	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (no alcohol)	0	1	2	3
Watching TV	0	1	2	3
As a passenger in a car for an hour	0	1	2	3
Lying down in the afternoon	0	1	2	3
In a car, stopped in traffic for a few minutes	0	1	2	3

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

0 = never
1 = slight chance
2 = moderate chance
3 = high chance

TOTAL SCORE: ___________

FAX BELOW INFORMATION TO:
N. BUFFALO 716.871.1998 or N. FALLS 716.242.0611:

- **Relevant clinical notes**
- **Insurance card**
- **Any previous sleep or HST studies**
- **Demographic sheet**
- **Medication list, including O_2**

Practitioner's signature ______________________________ Date ______________

Practitioner's name (PRINT) ______________________________ NPI # ______________

Practice name ______________________________ **Dental Practice Y N**

Reviewed by Kenneth Halliwell, MD, Medical Director ______________________________