



sleepinsights
Practicing Medicine. Perfecting Sleep.

SLEEP INSIGHTS SLEEP REFERRAL FORM

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Last name	First name	MI
Phone	DOB	Sex: M F
SELECT ONE:		
<input type="checkbox"/> CONSULTATION: Patient is seen for evaluation, any indicated sleep studies, CPAP titration/equipment, and follow up		
<input type="checkbox"/> Home Sleep Apnea Testing (HSAT) (CPT 95806)	<input type="checkbox"/> CPAP titration (CPT 95811)	
<input type="checkbox"/> PSG (polysomnogram) overnight sleep test (CPT 95810)	<input type="checkbox"/> Split-night study	

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

EPWORTH SLEEPINESS SCALE				
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				
SITUATION	0	1	2	3
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
TOTAL SCORE: _____				

MEDICAL HISTORY	
Clinical Conditions:	
<input type="checkbox"/> Mood disorders	<input type="checkbox"/> Obesity
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Congestive heart failure
<input type="checkbox"/> Atrial fibrillation	<input type="checkbox"/> Heart attack
<input type="checkbox"/> Stroke / TIA	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Lung disease	<input type="checkbox"/> Seizures / epilepsy
<input type="checkbox"/> Other:	
Symptoms	
<input type="checkbox"/> Loud Snoring	<input type="checkbox"/> Morning headaches
<input type="checkbox"/> Excessive sweating	<input type="checkbox"/> Acid reflux
<input type="checkbox"/> Witnessed apneas	<input type="checkbox"/> Memory impairment
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Excessive daytime sleepiness
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Restless legs syndrome
<input type="checkbox"/> Frequent nocturnal urination (nocturia)	
<input type="checkbox"/> Abnormal behaviors during sleep (sleepwalking, etc.)	
<input type="checkbox"/> Other:	

PLEASE FAX THE FOLLOWING TO (716) 871.1998:

- Clinical notes
- Insurance card
- Any previous sleep or HST studies
- Demographic sheet
- Medication list, including O₂

Practitioner's signature _____ Date _____

Practitioner's name (PRINT) _____ NPI # _____

Practice name _____ Dental Practice **Y N**

Reviewed by Kenneth Murray, MD, Medical Director _____