SLEEP INSIGHTS SLEEP REFERRAL FORM

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Last name First name MI

Phone DOB Sex: M F

SELECT ONE:

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

___ **Home Sleep Apnea Testing (HSAT)** (CPT 95806)
___ **PSG (polysomnogram) overnight sleep test** (CPT 95810)
___ **CPAP titration** (CPT 95811)
___ **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				
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:

___ Mood disorders
___ Hypertension
___ Atrial fibrillation
___ Stroke / TIA
___ Lung disease
___ Other:
___ Obesity
___ Congestive heart failure
___ Heart attack
___ Diabetes
___ Seizures / epilepsy

Symptoms

___ Loud Snoring
___ Excessive sweating
___ Witnessed apneas
___ Insomnia
___ Palpitations
___ Frequent nocturnal urination (nocturia)
___ Abnormal behaviors during sleep (sleepwalking, etc.)
___ Other:
___ Morning headaches
___ Acid reflux
___ Memory impairment
___ Excessive daytime sleepiness
___ Restless legs syndrome

PLEASE FAX THE FOLLOWING TO (716) 871.1998:

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

Practitioner's signature _____ Date _____

Practitioner's name (PRINT) _____ NPI # _____

Practice name _____ **Dental Practice Y N**

Reviewed by Kenneth Murray, MD, Medical Director _____