



SLEEP INSIGHTS SLEEP REFERRAL FORM

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Board certified in Neurology and Sleep Medicine

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SleepInsights.com

Last name	First name	MI
Phone	DOB	Sex: M F
SELECT ONE: CONSULTATION OR TESTING		
<input type="checkbox"/> CONSULTATION: <i>Patient is seen for evaluation, any indicated sleep studies, CPAP titration/equipment, and follow up.</i>		
TESTING		
<input type="checkbox"/> Home Sleep Apnea Testing (HSAT) (CPT 95806)	<input type="checkbox"/> Other:	
<input type="checkbox"/> PSG (polysomnogram) overnight sleep test (CPT 95810)		
<input type="checkbox"/> CPAP titration (CPT 95811)		
<i>If chart notes don't qualify patient for sleep testing coverage, we'll schedule patient for evaluation and order any indicated testing.</i>		

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

EPWORTH SLEEPINESS SCALE

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

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 O₂

Practitioner's signature _____ Date _____

Practitioner's name (PRINT) _____ NPI # _____

Practice name _____ Dental Practice **Y N**

Reviewed by Kenneth Halliwell, MD, Medical Director _____