SLEEP INSIGHTS SLEEP REFERRAL FORM

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Last name First name MI

Phone DOB Sex: M F

SELECT ONLY ONE:

___ **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

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 (585) 335.4290:

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

Practitioner's signature _____ Date _____

Practitioner's name (PRINT) _____ NPI # _____

Practice name _____ **Dental Practice Y N**

Reviewed by Kenneth Halliwell, MD, Medical Director _____