sleepinsights
Practicing Medicine. Perfecting Sleep.

SLEEP REFERRAL

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New Patient Visit: Attach patient demo sheet and and copy of insurance card.
Please fax this completed form to (716) 379-8439

Last Name	First	MI
Phone	D.O.B.	Sex M F
Insurance Co.	Authorization No.	Insurance Phone
Referring Physician		

SLEEP HISTORY

Nighttime Symptoms

_____ Snores during sleep
_____ Stops breathing during sleep *(Apneas observed by partner)*
_____ Choking or gasping sensation
_____ Experiences a restless sensation in the legs or arms at bedtime or during sleep
_____ Makes frequent kicking movements during sleep
_____ Has difficulty falling asleep at the beginning of the night, or difficulty staying asleep
_____ Need to urinate at night
_____ Sleepwalking, acting out of dreams or other behavioral episodes during sleep
_____ Other (please describe): _____

Daytime Symptoms

_____ Excessive daytime sleepiness: difficulty staying alert during the day, or report of fatigue
_____ Morning headaches
_____ Dry mouth, sore throat upon awakening
_____ Difficulty focusing and concentrating on tasks
_____ Memory impairment

Medical History:

Nasal:	____ Allergies	____ Sinus Problems	____ Deviated Septum	____ Nasal Polyps	____ Congestion
Oral:	____ Large Tongue	____ Large Tonsils	____ Small Pharyngeal Inlet	____ Friedman/mallampati I II III IV	
Resp:	____ Asthma	____ Emphysema / COPD	____ Dyspnea (SOB)	____ Low Overnight O_2 Saturation	
Cardiac:	____ HTN	____ CAD	____ Arrhythmia	____ CHF	____ Edema
GI:	____ Obesity	____ Hyperlipidemia	____ NASH	____ Diabetes	____ GERD
Neuro:	____ Seizures	____ Stroke	____ Cognitive Problem	____ Depression/Anxiety	____ Dementia

Exam: Weight _____ lbs. Height _____ inches Neck Circumference _____ inches BMI _____

Type of Referral:

____ Polysomnogram (PSG) ____ CPAP Titration Study ____ Split-Night Study ____ MSLT ____ MWT
____ Consultation with testing as needed ____ Home Sleep Testing (Only tests for breathing disorders: No sleep analysis)

Epworth Sleepiness Scale:

How likely are you to doze off or fall asleep in the situations described below, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to imagine how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	Chance of Dozing			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (i.e. a movie theater)	0	1	2	3
As a car passenger for more than one hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (without alcohol)	0	1	2	3
In a car, stopped for a few minutes in traffic	0	1	2	3

Score Key: Total Score _____
1–10 Normal Range 10–12 Borderline 12–24 Abnormal

Practitioner's Signature _____ Date _____

Practitioner's Name (print) _____ Phone _____