sleep insights HST

HST REFERRAL FORM

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Last name	First name	MI
Phone	DOB	Gender

REASON FOR REFERRAL

___ Home Sleep Apnea Testing (HST) -- CPT 95806

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

PLEASE INCLUDE THE FOLLOWING:

☐ Demographic sheet & insurance info
☐ Recent clinical notes / last history & physical
☐ Any previous sleep or HST studies
☐ Medication list, including O_2

FAX TO (716) 203.0099

Practitioner's signature _____ Date _____

Practitioner's name (PRINT) _____ NPI # _____

Practice name _____ **Dental Practice Y N**

Practice phone _____ fax _____ HST Approved Y N