DENTAL PRACTICE REFERRAL FORM

sleep insights
Practicing Medicine. Perfecting Sleep.

p (716) 250.7460
f (716) 203.0099
www.sleepinsights.com

Last name	First name			Phone
Address				
DOB	Gender	Weight	Height	BMI
Primary care provider:				Phone
Address				

SELECT ONE: CONSULTATION or TESTING ONLY

___ CONSULTATION: Patient is seen for evaluation, any indicated sleep studies and follow up
___ Home Sleep Apnea Testing (CPT 95806)
___ Repeat Home Sleep Apnea Testing after oral appliance titration

FILL OUT BELOW *only if requesting* TESTING ONLY

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 **3** = high

SITUATION	
Sitting and reading	
Sitting, inactive, in a public place	
Sitting and talking to someone	
Sitting quietly after lunch (no alcohol)	
Watching TV	
As a passenger in a car for an hour	
Lying down in the afternoon	
In a car, stopped in traffic for a few minutes	

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
___ Restless legs syndrome
___ Frequent nocturnal urination (nocturia)
___ Abnormal behavior during sleep (e.g. sleepwalking)
___ Excessive daytime sleepiness
___ Other:
___ Morning headaches
___ Nocturnal acid reflux
___ Memory impairment
___ Palpitations

MEDICATIONS or ADDITIONAL NOTES

☐ Patient isn't on medication

MEDICATIONS: (or attach list)

_____
_____
_____
_____
_____
_____
_____
_____
_____

PLEASE FAX THE FOLLOWING TO (716) 203.0099:

☐ Clinical notes ☐ *Medical* insurance card ☐ Previous sleep or HST studies

Dentist's signature _____ Date _____

Dentist's name (PRINT) _____ Auth Approved: Y N

Practice name _____ HST Approved: Y N