SLEEP TESTING REFERRAL FORM

Medical Directors
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Last name	First name	MI
Phone	DOB	Gender

SELECT ONE:

___ Home Sleep Apnea Testing (CPT 95806)
___ PSG / polysomnogram (CPT 95810)
___ PAP titration (CPT 95811)
___ Other:

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:				

EPWORTH SLEEPINESS SCALE
Please fill out if requesting testing.

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

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 PREFERRED LOCATION:

Rochester	f (585) 385.6071	N. Buffalo/Orchard Park	f (716) 662.1125
Batavia	f (585) 310.7447	Niagara Falls	f (716) 242.0611
Geneseo/Dansville	f (585) 335.4290	Olean	f (716) 379.8439

Practitioner's signature _____ Date _____

Practitioner's name (PRINT) _____ NPI # _____

Practice name _____ **Dental Practice Y N**