SLEEP REFERRAL FORM

p (585) 385.6070 | f (585) 385.6071
sleepinsights.com

Last name	First name	MI
Phone	DOB	Gender

SELECT CONSULTATION OR TESTING

CONSULTATION

___ Patient seen for evaluation, any indicated sleep studies, CPAP titration/equipment, and follow up

TESTING

___ Home Sleep Apnea Testing (CPT 95806)
___ PSG / polysomnogram (CPT 95810)
___ Other:
___ Split night (if PSG criteria is met)
___ CPAP titration (CPT 95811)

FILL OUT EPWORTH SLEEPINESS SCALE IF REQUESTING TESTING

How likely are you to doze off or fall asleep in the following situations, compared to just feeling tired?

0 = NO CHANCE **1** = SLIGHT CHANCE **2** = MODERATE CHANCE **3** = HIGH CHANCE

	0	**1**	**2**	**3**
Sitting and reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting, inactive, in a public place	☐	☐	☐	☐
As a passenger in a car for an hour	☐	☐	☐	☐
Lying down to rest in the afternoon	☐	☐	☐	☐
Sitting and talking to someone	☐	☐	☐	☐
Sitting quietly after lunch (no alcohol)	☐	☐	☐	☐
In a car, stopped for a few minutes in traffic	☐	☐	☐	☐

TOTAL SCORE:________

FAX THE FOLLOWING to (585) 385.6071

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

☐ ***If this box is not checked you are responsible for patient follow up care after direct testing referrals only.***

Practitioner's signature ____ Date ________________

Practitioner's name (PRINT) ____ NPI # ________________

Practice name ____ **Dental Practice Y N**