

# REFERRAL FORM

DATE & TIME OF SLEEP STUDY: \_\_\_/\_\_\_/\_\_\_ @ \_\_\_:\_\_\_AM/PM WAITING LIST?  Yes  No

FAX TO: 508-961-0699 with most recent History & Physical Notes with this form (for non-Hawthorn referrals)

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Hawthorn ID: \_\_\_\_\_ Male/Female: (circle)  
Address: \_\_\_\_\_ Insurance: \_\_\_\_\_ Subscriber: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_  
Phone #s: \_\_\_\_\_ (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Work)

## SLEEP STUDY/EVALUATION REQUESTED (Please check appropriate boxes)

- |   |   |
|---|---|
| <input type="checkbox"/> <b>Consultation and Management</b><br>▶ Visit with a sleep specialist for evaluation and treatment   | <input type="checkbox"/> <b>PSG &amp; Multiple Sleep Latency Test</b><br>▶ All night PSG with next day MSLT study   |
| <input type="checkbox"/> <b>Diagnostic Sleep Study (PSG)</b><br>▶ All night diagnostic polysomnogram, no CPAP initiation  | <input type="checkbox"/> <b>Sleep Study with Full EEG</b><br>▶ Overnight video-EEG monitoring with PSG to evaluate for nocturnal seizures, other causes of sleep disruption or cognitive dysfunction  |
| <input type="checkbox"/> <b>Split Night Study</b><br>▶ Includes CPAP initiation and titration if clinical criteria are met  | <input type="checkbox"/> <b>CPAP Therapy DME Clinic</b><br>▶ Visit with sleep specialist to review results<br>▶ Meet with DME Coordinator for PAP equipment<br>▶ View equipment instructional DVD<br>▶ Mask fitting and compliance management |
| <input type="checkbox"/> <b>CPAP or BIPAP or ASV (VPAP)* (circle one)</b><br>▶ OSA or UARS must already be documented<br><br>* CPAP must be previously proven ineffective |   |

## MEDICAL HISTORY Criteria must include: SNORING AND/OR RESTLESSNESS with one of the following:

- | <u>Primary Symptom(s)</u>                             | <u>Suspected Disorder(s)</u>                            | <u>Special Needs</u> (check appropriate boxes)                            |
|---|---|---|
| <input type="checkbox"/> Gasping/Choking              | <input type="checkbox"/> Obstructive Sleep Apnea (OSA)  | <input type="checkbox"/> Patient is on home oxygen and use during study   |
| <input type="checkbox"/> Excessive Daytime Sleepiness | <input type="checkbox"/> Insomnia                       | <input type="checkbox"/> Administer O2 if baseline is <88%, max ___ L/min |
| <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Narcolepsy                     | <input type="checkbox"/> Patient has tape, latex allergies                |
| <input type="checkbox"/> Depression                   | <input type="checkbox"/> Seizures/Parasomnias           | <input type="checkbox"/> Patient has CPAP compliance problems             |
| <input type="checkbox"/> Pulmonary Disease            | <input type="checkbox"/> Restless Legs Syndrome (RLS)   | <input type="checkbox"/> Patient needs a translator _____ (language)      |
| <input type="checkbox"/> Hypertension                 | <input type="checkbox"/> Periodic Limb Movements (PLMS) | <input type="checkbox"/> Patient needs a wheelchair                       |

DO YOU WANT THE READING PHYSICIAN TO FOLLOW UP WITH PATIENT CARE?  No  Yes

## PHYSICIAN INFORMATION

### Referring Physician

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Phone #: \_\_\_\_\_  
Fax #: \_\_\_\_\_

### Primary Care Physician

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Phone #: \_\_\_\_\_  
Fax #: \_\_\_\_\_

▶ Signature: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_