SUNY Downstate Medical Center

SLEEP DISORDERS CENTER
3839 Flatlands Avenue, Brooklyn, NY 11234
Phone (718) 252-1117 • Fax (718) 252-4185
www.downstate.edu/sleep

Referral for Adult & Pediatric Sleep Studies and Consultations

1. Complete all information on the front of this form.
2. Complete the appropriate section on the back of this form for either an ADULT or PEDIATRIC sleep study or consultation.
3. Fax the referral form to the Sleep Disorders Center (718) 252-4185.

PATIENT INFORMATION

Patient's Name: ______________________ Date of Birth: ________ /________ /________ Sex: ❐ M ❐ F

Address: ____

Home Phone: ______________ Work Phone: ______________ Cell Phone:______________

Email: ______________________ Patient's SS #: ______________________

Patient Height: __________ Patient Weight: __________

Emergency Contact Name: ______________________ Emergency Phone #: ______________________

INSURANCE

Insurance Carrier: ______________ Name of Insured : ______________ Insurance Phone #:______________

Policy ID#: ______________ Group #: ______________ Insured's SS #: ______________

REFERRING PHYSICIAN

Referring physician (print): ____

Office Address: ____

Office Phone: ______________ Office Fax: ______________ Doctor's Email: ______________

Physician's Signature: ______________________________ **Date:** ________ /________ /__________

PLEASE NOTE:

The Sleep Disorders Center is conveniently located at the intersection of Flatlands and Flatbush Avenues. Secured parking is available.
If patient requires assistance in getting to the site, please call us to make arrangements for transportation.
We accept most insurance plans, including Medicare and Medicaid.

University Physicians of Brooklyn Sleep Disorders Center
3839 Flatlands Avenue, Brooklyn, NY 11234 • Phone (718) 252-1117 • Fax (718) 252-4185

Order for ADULT Sleep Study or Consultation

PATIENT HISTORY / INDICATIONS FOR STUDY OR CONSULTATION

(Please check all that apply)

- ❏ Snoring
- ❏ Daytime sleepiness or fatigue
- ❏ Discomfort or restlessness of lower limbs before or during sleep
- ❏ Tracheostomy tube
- ❏ Home suctioning – trach/nasal/oral
- ❏ Gasping or choking during sleep
- ❏ Apneic events witnessed by bed partner
- ❏ Twitching, jerking or kicking of lower limbs before or during sleep
- ❏ Home oxygen use ________LPM

Medical conditions/diagnoses: ____

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Please list all current medications:

Medication: ____________________ Dose: ______________
Medication: ____________________ Dose: ______________
Medication: ____________________ Dose: ______________
Medication: ____________________ Dose: ______________
Medication: ____________________ Dose: ______________
Medication: ____________________ Dose: ______________

TYPE OF STUDY REQUESTED

- ❏ Consultation Only
- ❏ Nocturnal Polysomnography (NPSG)
- ❏ Split Night Study
- ❏ Maintenance of Wakefulness Test (MWT)
- ❏ Arrange for CPAP / BiPAP equipment, if needed
- ❏ CPAP / BiPAP Titration Study
- ❏ Multiple Sleep Latency Test (MSLT)
- ❏ CPAP / BiPAP Titration Study (if indicated by the outcome of NPSG)

RULE OUT OR CONFIRM THE FOLLOWING

- ❏ Sleep Apnea
- ❏ Periodic Limb Movement Syndrome
- ❏ Daytime Sleepiness
- ❏ Insomnia
- ❏ Narcolepsy
- ❏ Other: ______________________________________

Order for PEDIATRIC Sleep Study or Consultation

PATIENT HISTORY / INDICATIONS FOR STUDY OR CONSULTATION

(Please check all that apply)

- ❏ Snoring or noisy breathing
- ❏ Mouth breathing
- ❏ Neuromuscular weakness
- ❏ Restlessness
- ❏ Daytime irritability or hyperactivity
- ❏ Tracheostomy tube
- ❏ Home suctioning – trach/nasal/oral
- ❏ Gasping or choking during sleep
- ❏ Difficulty breathing
- ❏ Observed apnea
- ❏ Daytime sleepiness or fatigue
- ❏ Poor school performance
- ❏ Home oxygen use ________LPM

Has this patient had a prior study in our lab? ❏ Yes ❏ No
Is the patient on CPAP or BiPAP at home? ❏ Yes ❏ No
Does the patient have a feeding tube? ❏ Yes ❏ No
Does the patient have a neurological disorder? ❏ Yes ❏ No

Medical conditions/diagnoses: ____

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Please list all current medications:

Medication: ____________________ Dose: ______________
Medication: ____________________ Dose: ______________
Medication: ____________________ Dose: ______________
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Medication: ____________________ Dose: ______________
Medication: ____________________ Dose: ______________

TYPE OF STUDY REQUESTED

- ❏ Consultation Only
- ❏ Nocturnal Polysomnography (NPSG)
- ❏ Split Night Study
- ❏ Multiple Sleep Latency Test (MSLT)
- ❏ CPAP / BiPAP Titration Study
- ❏ Arrange for CPAP / BiPAP equipment, if needed

Please note that the study requested can be scheduled only if the patient's demographic and medical history are accurately provided above.