

REFERRAL FOR ADULT & PEDIATRIC SLEEP STUDIES

1. Complete all information on the front of this form.
2. Complete the appropriate section on the reverse side of this form for either an ADULT or PEDIATRIC sleep study.
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.*

ORDER FOR ADULT SLEEP STUDY

PATIENT HISTORY / INDICATIONS FOR STUDY

(Please check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Gasping or choking during sleep |
| <input type="checkbox"/> Daytime sleepiness or fatigue | <input type="checkbox"/> Apneic events witnessed by bed partner |
| <input type="checkbox"/> Discomfort or restlessness of lower limbs before or during sleep | <input type="checkbox"/> Twitching, jerking or kicking of lower limbs before or during sleep |
| <input type="checkbox"/> Tracheostomy tube | <input type="checkbox"/> Home oxygen use _____ LPM |
| <input type="checkbox"/> Home suctioning – trach/nasal/oral | |

Medical conditions/diagnoses: _____

Please list all current medications:

Medication: _____	Dose: _____	Medication: _____	Dose: _____
Medication: _____	Dose: _____	Medication: _____	Dose: _____
Medication: _____	Dose: _____	Medication: _____	Dose: _____

TYPE OF STUDY REQUESTED

- | | |
|--|---|
| <input type="checkbox"/> Nocturnal Polysomnography (NPSG) | <input type="checkbox"/> CPAP / BiPAP Titration Study |
| <input type="checkbox"/> Split Night Study | <input type="checkbox"/> Multiple Sleep Latency Test (MSLT) |
| <input type="checkbox"/> Maintenance of Wakefulness Test (MWT) | <input type="checkbox"/> CPAP / BiPAP Titration Study (if indicated by the outcome of NPSG) |
| <input type="checkbox"/> Arrange for CPAP / BiPAP equipment, if needed | |

RULE OUT OR CONFIRM THE FOLLOWING

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Periodic Limb Movement Syndrome | <input type="checkbox"/> Narcolepsy |
| <input type="checkbox"/> Daytime Sleepiness | <input type="checkbox"/> Other: _____ |

ORDER FOR PEDIATRIC SLEEP STUDY

PATIENT HISTORY / INDICATIONS FOR STUDY

(Please check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Snoring or noisy breathing | <input type="checkbox"/> Gasping or choking during sleep |
| <input type="checkbox"/> Mouth breathing | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Neuromuscular weakness | <input type="checkbox"/> Observed apnea |
| <input type="checkbox"/> Restlessness | <input type="checkbox"/> Daytime sleepiness or fatigue |
| <input type="checkbox"/> Daytime irritability or hyperactivity | <input type="checkbox"/> Poor school performance |
| <input type="checkbox"/> Tracheostomy tube | <input type="checkbox"/> Home oxygen use _____ LPM |
| <input type="checkbox"/> Home suctioning – trach/nasal/oral | |

Has this patient had a prior study in our lab?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the patient on CPAP or BiPAP at home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the patient have a feeding tube?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the patient have a neurological disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Medical conditions/diagnoses: _____

Please list all current medications:

Medication: _____	Dose: _____	Medication: _____	Dose: _____
Medication: _____	Dose: _____	Medication: _____	Dose: _____
Medication: _____	Dose: _____	Medication: _____	Dose: _____

TYPE OF STUDY REQUESTED

- | | |
|---|--|
| <input type="checkbox"/> Nocturnal Polysomnography (NPSG) | <input type="checkbox"/> CPAP / BiPAP Titration Study |
| <input type="checkbox"/> Split Night Study | <input type="checkbox"/> Arrange for CPAP / BiPAP equipment, if needed |
| <input type="checkbox"/> Multiple Sleep Latency Test (MSLT) | |

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