



REFERRAL FORM

PHONE: (401) 821-1896
FAX: (401) 821- 3174

PATIENT INFORMATION (Please Print)

Email: _____

Name: _____

M/F: _____ DOB: _____

Address: (street) _____

Home tel.#(____) _____

(city, state, zip) _____

Work tel.#(____) _____

INSURANCE: _____ ID# _____ SUBSCRIBER _____

THIS PATIENT IS BEING REFERRED FOR: (Please check all that apply.)

Indications for Sleep Study:

- Hypersomnolence/ Excessive Daytime Sleepiness
- Insomnia
- Parasomnia (Abnormal Movements/ Behavior In Sleep)
- C-PAP/Bi-Level Titration (Or Re-Evaluation) For Previously Diagnosed OSAS
- Other _____

Study Type:

- Standard Polysomnography (Standard Overnight Sleep study)
- C-PAP/Bi-Level Titration (Therapy For Sleep Apnea)
- SPLIT Study (Combined Polysomnography and C-PAP/Bi-Level Titration for patients with high clinical suspicion of OSAS)

RELEVANT MEDICAL HISTORY (Please forward most recent history and physical)

Suspected Disorder: (Check all that apply)

Special Needs

- Obstructive Sleep Apnea Syndrome (OSAS)
- Periodic Leg Movement Syndrome (PLMS)
- Narcolepsy
- Nocturnal Seizures/ Parasomnias
- Other _____

- O2 _____ Wheelchair
- Other _____

Comments: _____

Primary Symptoms

- Loud Snoring
- Daytime Sleepiness
- Obese/Large Neck
- Witnessed Apneas
- Frequent Leg Movements during sleep
- Difficulty falling asleep
- Fragmented Sleep

REFERRING PHYSICIAN: (Please Print)

Email: _____

NAME: _____ PHONE: _____ FAX _____

ADDRESS: _____ (city, state, zip) _____

PRIMARY CARE PHYSICIAN: (Please Print) Same as Referring Physician? Yes No

Name: _____ Phone: (____) _____ Fax: (____) _____

REFERRING PHYSICIANS SIGNATURE _____ **Date** _____