TRINITAS HOSPITAL

REFERRAL FORM FOR SLEEP EVALUATION

AMERICAN ACADEMY OF SLEEP MEDICINE — WAKE SLEEP — MEMBER CENTER

SLEEP DISORDERS CENTER AT TRINITAS HOSPITAL

PATIENT NAME: _____ DATE OF BIRTH: _____

HOME TELEPHONE: _____ CELL NUMBER: _____

SERVICES REQUESTED: (PLEASE COMPLETE **EITHER** OF THE FOLLOWING SECTIONS)

OR

☐ SLEEP STUDY ONLY. PLEASE FILL OUT AND FAX THIS H/P FORM TO SLEEP CENTER FOR REVIEW BY D'ABSM.

HISTORY AND PHYSICAL

SLEEP PROBLEMS

- Witnessed Apnea
- Excessive Daytime Sleepiness
- Snoring
- Frequent Awakenings
- Morning Headaches
- Tiredness Fatigue
- Insomnia
- Cataplexy
- Sleep Walking Talking
- Restless Legs
- Sleep Paralysis
- Convulsions

MEDICAL CONDITIONS

- HTN
- CHF
- Cardiac Arrhythmias
- Stroke Seizures
- GERD
- Diabetes
- COPD Asthma
- Other: _____
- Depression
- Thyroid Dysfunction
- Obesity

PHYSICAL EXAM

Heart:	Normal	Abnormal
Lungs:	Normal	Abnormal
Abdomen:	Normal	Abnormal
CNS:	Normal	Abnormal
Peripheral Edema:	_____	
BMI:	_____	
Weight:	_____	
Neck Size:	_____	

HEENT		
Nose:	Normal	Abnormal
Tongue:	Normal	Abnormal
Dentition:	Normal	Abnormal
Uvula:	Normal	Abnormal
Tonsils:	Normal	Abnormal
Soft Palate:	Normal	Abnormal
Friedman Scale	_____	

PRESUMPTIVE DIAGNOSIS

- Sleep Apnea
- Narcolepsy
- PLMD Restless Legs
- Nocturnal Seizures
- Sleepwalking
- Hypersomnia
- Insomnia
- Other _____

TYPE OF STUDY

- Basic Polysomnogram CPT 95810
- CPAP BiPAP Titration CPT 95811
- Split Night CPT 95811
- MSLT CPT 95805****
- MWT CPT 95805*****

****Need Sleep Medicine Consultation

ACCREDITED BY AMERICAN ACADEMY OF SLEEP MEDICINE