



p 585-385-6070
 f 585-385-6071
 tf 877-385-6070

SLEEP EVALUATION REFERRAL

Patient referral information for sleep services: please fax to: 585-385-6071

Last name	First	MI
Phone	DOB	Sex M F
Insurance Co.	Authorization #	Per
Insurance Phone #	Please attach a photocopy of the patient's insurance card	

Verification of Medical Necessity:

Sleep History:

- Snores excessively during sleep
- Stops breathing during sleep
- Excessive daytime sleepiness: difficulty staying alert during the day, or report of extreme fatigue
- Awakens from sleep with gasping or choking; dry mouth or throat upon awakening
- Experiences a restless sensation in the legs or arms at bedtime or during sleep
- Makes frequent kicking movements during sleep
- Has difficulty falling asleep at the beginning of the night, or difficulty staying asleep
- Has morning headaches
- Sleepwalking or other behavioral episodes during sleep
- Other (please describe) _____

Medical History and Pertinent Physical Findings:

Nasal: Allergies Sinus Problems Deviated Septum Nasal Polyps Congestion
 Oral: Large Tongue Large Tonsils Small Pharyngeal Inlet
 Resp: Asthma Emphysema Dyspnea (SOB) Low Overnight O₂ Saturation
 Cardiac: HTN CAD Arrhythmia CHF Edema
 GI: Obesity: mild moderate severe Diabetes GERD
 Neuro: Seizures Stroke Cognitive Prob. Depression/Anxiety

Exam: Weight: _____ lbs. Height: _____ inches Neck Circumference: _____ inches

Type of Sleep Study Requested:

Polysomnogram (PSG) CPAP Titration Study Split-Night Study MSLT
 Home Sleep Testing (only tests for breathing disorders: no sleep analysis)

Practitioner's Signature _____ Date _____

Practitioner's Name (print) _____ Phone _____

Internal Use only: Test as indicated above Test as follows _____

Approved by: _____