701 E. COUNTY LINE ROAD, SUITE 207. GREENWOOD, IN 46143
OFFICE: 317-887-6400 FAX 317-887-6500 indianasleepcenter.com

DIRECT REFERRAL FOR SLEEP STUDY

Thank you for the referral of your patient. The American Academy of Sleep Medicine requires the following patient information per Accreditation Standards. Additionally, the information will enable our sleep physicians to tailor the study to best fit your patient's needs. **Please note: A recent office note may be substituted for this form if it contains the information that has been Bold/Italicized below.**

PATIENT DEMOGRAPHICS

Name: ______________________________ Home Phone:______________________ Alternate Phone:______________________

Date of Birth:_______________________ Gender: M / F

Sleeping Hours: From __________ to ____________ ☐ Night ☐ Day ☐ Evening

PHYSICIAN INFORMATION

Requesting Physician: ______________________________ Phone: ___________________ Fax: ____________________

PCP: ____ Phone: ___________________ Fax____________________

◆◆

Epworth Sleepiness Scale score:_____________ or Berlin Questionnaire included.

HISTORY AND PHYSICAL INFORMATION ***(Choose at least one)***

- ☐ ***Excessive Daytime Sleepiness***
- ☐ ***Witnessed Apneas***
- ☐ ***Snoring /Gasping/Choking***
- ☐ ***Morning Headaches***
- ☐ Shift Work
- ☐ Cataplexy
- ☐ Nocturia
- ☐ Sleep Paralysis
- ☐ Sleepwalking
- ☐ Claustrophobia
- ☐ Frequent Awakenings

History of Sleep Problem

____
____
____
____

MEDICAL CONDITIONS ***(Choose at least one)***

- ☐ ***Hypertension***
- ☐ ***CHF/CAD (Ischemic Heart Disease)***
- ☐ ***Hx. Stroke***
- ☐ ***Insomnia***
- ☐ ***Impaired Cognition***
- ☐ ***Mood Disorders***
- ☐ Diabetes
- ☐ Asthma/COPD
- ☐ Chronic Pain
- ☐ Fibromyalgia
- ☐ Seizures
- ☐ Cardiac Arrhythmias
- ☐ GERD

Other Medical Conditions

____
____
____
____

MEDICATIONS:____

PHYSICAL EXAM:

Height_________ Weight_________ lbs. ***BMI:*** _________ ***Neck Size______"***

HEENT:____ Neurologic:____

Chest:____ ***Cardiac:***____

SPECIAL NEEDS:

☐ Oxygen ☐Assistance Moving ☐ Wheelchair ☐Difficulty Communicating ☐ Other:_________________________________

◆◆

SLEEP STUDY TYPE(S): ☐ STANDARD ☐ CPAP/BIPAP TITRATION ☐ MSLT/MWT

DIAGNOSIS (presumptive):

- ☐ Obstructive Sleep Apnea
- ☐ PLMD/Restless Legs
- ☐ Narcolepsy
- ☐ Hypersomnia
- ☐ Sleep Associated Behaviors
- ☐ Neuromuscular Diease

ORDERING PHYSICIAN SIGNATURE: ____DATE:______________________

I would like for my patient to see one of the Sleep Medicine physicians in consultation ? ☐***Yes*** ☐ ***No***

Note: Medicare patients placed on CPAP require a follow-up office visit with the treating physician 31 to 91 days after PAP delivery. Documentation of subjectively improved OSA symptoms and objective evidence of PAP compliance are required per medicare guidelines.