SLEEP REFERRAL SCREENING & ORDER FORM

Patient Name ________________________________ **M / F DOB**_______________

- ❑ Snoring, most nights
- ❑ I've been told I stop breathing, choking, gasping for air while sleeping
- ❑ Excessive daytime sleepiness
- ❑ Falling asleep or dozing while driving, at work, or other public place
- ❑ Often wake up feeling unrefreshed, tired, not rested after 7 to 10 hours of sleep time
- ❑ Sweating during sleep
- ❑ Wake up with a headache and/or morning headaches
- ❑ High blood pressure
- ❑ Unexplained hypertension
- ❑ MI (Myocardial Infarction)
- ❑ Stroke
- ❑ Diabetes
- ❑ Neck size (in inches) ___________
- ❑ Height: ______'________" Weight: ________lbs., BMI= _________

EPWORTH SLEEPINESS SCALE

Please number the following situations 0-3 based on how likely you are to fall asleep.

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	CHANCE OF DOSING
Sitting and reading	______
Watching TV	______
Sitting, inactive in a public place (theater, meeting, etc)	______
As a passenger in a car for an hour without a break	______
Lying down to rest in the afternoon when circumstances permit	______
Sitting and talking to someone	______
Sitting quietly after a lunch without alcohol	______
In a car, while stopped for a few minutes in the traffic	______
TOTAL SCORE =	_____

PHYSICIAN'S ORDER

- ❑ Evaluate & Treat
- ❑ Sleep Study (1 night only)
- ❑ Sleep Study & CPAP Study (if qualifying)
- ❑ Other ______________________

Follow up with: [] Ordering Physician [] Sleep Physician [] Other ______________________

Referring Physician(print):______________________ **Referring Office:**_________________________

Scheduler Name: ________________ **Phone:** ___________________ **Fax:** ____________________

Physician *Signature*: X____ **Date:** _______________

*** FAX this sheet with patient demos & copy of insurance card (Front & Back)**

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