SDI
SLEEP DISORDERS INSTITUTE
TEL: 212-994-5100
FAX: 212-994-5101
330 W 58th Street, Suite 509,
New York, NY 10019

SLEEP EVALUATION REQUEST

REFERRAL DATE ___/___/___

Please complete this form and return by fax to **212.994.5101**. SDI's Sleep Care Specialist will contact the patient to schedule tests that you have ordered. This form is not an insurance referral. Your patient may need to contact his/her primary care physician to obtain a valid insurance referral.

PATIENT INFORMATION

PATIENT NAME _____ DATE OF BIRTH ___/___/___
ADDRESS _____ E-MAIL _____
HOME _____ MOBILE _____ WORK _____
INSURANCE CARRIER _____ ID NUMBER _____

TYPE OF VISIT / TEST REQUESTED

- ☐ **I request that the visit or procedure be determined by a physician at the Sleep Disorders Institute.**
- ☐ Overnight Oximetry
- ☐ Seizure Monitoring
- ☐ Initial Consult
- ☐ Follow-Up Visit
- ☐ Nocturnal Polysomnogram
- ☐ Nasal CPAP Titration
- ☐ Weight Loss Program
- ☐ Home Sleep Testing
- ☐ Split Night
- ☐ Multiple Sleep Latency Test
- ☐ Maintenance of Wakefulness Test (MWT)

PATIENT REFERRED TO RULE OUT OR CONFIRM THE FOLLOWING:

- ☐ Sleep Apnea
- ☐ Insomnia
- ☐ Daytime Sleepiness
- ☐ Restless Legs
- ☐ Periodic Limb Movement Disorder
- ☐ Narcolepsy
- ☐ Other _____

PATIENT HISTORY

Snoring ☐ Yes ☐ No
Gasping or choking during sleep ☐ Yes ☐ No
Apneic events witnessed by bed partner ☐ Yes ☐ No
Discomfort or restlessness of lower limbs before or during the sleep ☐ Yes ☐ No
Twitching, jerking, or kicking of lower limbs before or during the sleep period ☐ Yes ☐ No
Daytime sleepiness or fatigue ☐ Yes ☐ No
Previous diagnosis of OSA? ☐ Yes ☐ No
If yes, is patient on CPAP? ☐ Yes ☐ No
If on CPAP, at what pressure? _____
Has upper airway surgery been performed? ☐ Yes ☐ No
Height _____ ft. _____ in. Weight _____ lbs. Blood Pressure _____ / _____
Medical Conditions (include recent surgeries) _____
Current Medications _____
Allergies _____ ENT Exam _____
Is the patient a commercial driver? ☐ Yes ☐ No
Is assistance required for language, translation, ambulation, toileting, or other activities? If yes, please explain:
_____

REFERRING PHYSICIAN

NAME _____ TELEPHONE _____
SPECIALTY _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____ NPI# _____
SIGNATURE _____ FAX _____ E-MAIL _____
How did you hear about the Sleep Disorders Institute? _____
Is this your first time referring to the Sleep Disorders Institute? ☐ Yes ☐ No

FOR OFFICE USE ONLY
Date Referral Received ___ ___ ___
Date Entered Into System ___ ___ ___
Date Processed ___ ___ ___
Date Scheduled ___ ___ ___