Santa Monica
SleepDisordersCenter
at St. John's Medical Plaza
Daniel Norman, M.D., Medical Director
Paul B. Haberman, M.D.
Diplomates, American Board of Sleep Medicine

1301 Twentieth St., Suite 370
Santa Monica, CA 90404

Tel: (310) 828-2293
Fax: (310) 453-3759

# SLEEP SERVICES REFERRAL FORM

Thank you for referring your patient to our center. Please provide the following information and pertinent medical records so that we can provide the best and most timely service.

**Referring Physician:** _____ **Ph:** _____ **Fax**:_____

**Patient's Name:** _____ **D.O.B.**_____ **Ph.**:_____

**Address:** _____ **City**: _____ **Zip code**:_____

## CONSULTATION REQUEST:

□ Sleep Specialist Consultation - testing will be performed only if / when appropriate
□ Following Sleep Study Requested Below

## TESTING REQUEST:

□ **Home Sleep Apnea Study**: 2-night baseline / diagnostic study only - for patients with a high pretest probability of obstructive sleep apnea (please note that if the patient does not qualify for home testing based on AASM guidelines, or is unable to perform a home study, a lab study will be performed unless checked here □)
□ 3 night study with titration of oral appliance each night per dentist's instructions

□ **Lab-Based Polysomnography**: an attended sleep study performed as:
□ baseline testing only □ split study with CPAP if qualifies, □ PAP titration all night
□ assess efficacy of oral appliance therapy in current position, □ with titration of oral appliance
□ baseline followed by MSLT (for patients suspected of having narcolepsy)
(please note that if the patient's insurance does not authorize a lab-based study, an at-home study will be performed instead of baseline-only test, unless checked here □)

**Clinical Diagnosis** (please check one): □ Obstructive Sleep Apnea □ Narcolepsy □ Other: _____

## For insurance authorization for testing services, please complete the following:

**Signs & Symptoms:**
□ Habitual snoring □ Excessive daytime sleepiness □ Epworth Sleepiness Scale Score >10,
□ Observed apnea during sleep □Inappropriate daytime napping □ Sleepiness that interferes w/daily activities
□ Unexplained hypertension □ Gasping/choking episodes associated with awakenings
□ Soft tissue abnormalities or neuromuscular diseases involving the craniofacial area or upper airway
□ Obesity □ BMI > 30, or Patient height: _____ft _____in Patient weight: _____lbs

**Potential Contraindications to a Home Study** (these vary per insurance plan):
□ Moderate or severe COPD/asthma □ Severe CHF □ $O_2$ dependent for any reason □ CAD
□ Cognitive impairment □ Neuromuscular impairment □ Previous CVA/TIA
□ Parasomnias □ Central Sleep Apnea □ Morbid Obesity (BMI >45)
□ Significant arrhythmias (please circle which): atrial fibrillation / ventricular fibrillation / ventricular tachycardia / bradycardia)

**Doctor's Signature**: _____ **Date:**_____

***Please fax a demographic "face sheet" with the most recent clinic note, and insurance information.

**Thank you for the referral!**