Dartmouth Health

Cheshire Medical Center

Phone (603) 650-3630
Fax: (603) 676-4080
Medically Urgent Fax: (603) 640-1909

Referring Provider: ______________________ Office Phone: ______________

Practice Name: ______________________ Fax: ______________

Practice Address ______________________ PCP Name: ______________

Patient Name: ______________________ MRN# ______________

DOB: __________ Cell Phone __________ Home Phone __________ Work Phone __________

Mailing Address: ______________________

Will a supplied interpreter be needed for this appointment? ❑ No ❑ Yes Language: ______________

Health Insurance: ______________________ Subscribers Name: ______________

Policy #: ______________ Group# ______________ Subscribers DOB ______________

Referral for Sleep Disorders Center

Request for: (please check one):

Sleep Medicine Consult

Please Include:

H&P Office Note with Medications

Overnight Sleep Study _____

Sleep Study Request Must Include:

Epworth Sleepiness Scale

Prior Authorization Form

H&P Office Note with Medications Medical conditions:

Using Oxygen: ❑ No ❑ Yes __________ lpm ❑ Nighttime ❑ Continuous ❑ Tracheotomy

Physically disabled: ❑ No ❑ Yes (explain) ______________________

Developmentally disabled: ❑ No ❑ Yes (explain) ______________________

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Reason for Referral: ______________________

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Indications/Chief Complaints: check all that apply

❑ Mood Disorders ❑ Retrognathia, tonsillar hypertrophy, Soft tissue abnormalities

❑ Mallampati score of 3 or 4: ______________________

Class 1: Full visibility of tonsils, uvula and soft palate
Class 2: Visibility of hard and soft palate, upper portion of tonsils and uvula
Class 3: Soft and hard palate and base of the uvula are visible
Class 4: Only Hard Palate visible

❑ Neuromuscular diseases involving the craniofacial area or upper airway

Continued ➔

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Co-Morbidities

- ❏ Impaired Cognition/Dementia
- ❏ Unexplained Pulmonary Hypertension
- ❏ Moderate to severe congestive heart failure
- ❏ Diagnosed, Significant Cardiac Arrhythmia not controlled by medication
- ❏ Moderate to severe pulmonary disease
- ❏ Neuromuscular Weakness
- ❏ Neurodegenerative Disorder
- ❏ Polycythemia with Hg > 18.5 g/dL in male; >16.5 g/dL in females
- ❏ Complex Sleep Disordered Breathing
- ❏ Stoke, TIA Date occurred ________________
- ❏ Recent change in BMI >5
- ❏ Is the patient on PAP therapy?
- ❏ Is the patient using a dental device?

Signs and Symptoms: Check all that apply

- ❏ Observed Apnea
- ❏ Snoring
- ❏ Morning Headaches
- ❏ Restless Legs
- ❏ Periodic Limb Movements
- ❏ COPD
- ❏ Daytime Sleepiness
- ❏ Insomnia
- ❏ CHF
- ❏ Frequent unexplained arousals
- ❏ Non restorative sleep
- ❏ Gasping/choking
- ❏ Parasomnia (e.g. sleepwalking)
- ❏ High BP

Has the patient had a prior sleep test? ❏ No ❏ Yes

If yes please include the results if available or provide the date of test, type of procedure and AHI. ____________________

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Did the patient have a recent T/A, UPPP or other ENT surgery? ❏ No ❏ Yes

If so, date of procedure:____

Is the patient able to perform a Home Sleep Test if one is requested by their insurance? ❏ No ❏ Yes

If not, why?____

Physically or Developmentally Disable: ❏ No ❏ Yes ____

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Requires Caregiver: (Technologist cannot provide nursing care) ❏ No ❏ Yes

Additional Information: ____

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