Dartmouth Health

Dartmouth Hitchcock Clinics
LITTLETON REGIONAL HOSPITAL

Phone (603) 650-3630
Fax: (603) 676-4080

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

Reason for referral:

Prior PSG: ❑ No ❑ Yes When _____ (please forward copy) Height: _____ Weight: _____

Signs and symptoms: (check all that apply)

❑ Observed apnea ❑ Daytime sleepiness ❑ Snoring ❑ CHF ❑ Periodic limb movements ❑ Insomnia

❑ Restless legs ❑ Morning headaches ❑ COPD ❑ High BP ❑ Parasomnia (e.g. sleepwalking)

Medical conditions:

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

Physically disabled: ❑ No ❑ Yes (explain) _____

Developmentally disabled: ❑ No ❑ Yes (explain) _____

Other medical conditions: _____

_____

_____

_____

_____

Please attach with this form:

❑ Medication list ❑ Previous office notes for sleep issues ❑ Previous Sleep Study Records