

**Referral Form**  
**Sleep Disorders Center**

**Fax form to:**  
Fax: (603) 676-4080

**Please indicate preference:**  DHMC Referral  CVH Referral Today's date: \_\_\_\_\_

**Patient name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

**Home phone:** \_\_\_\_\_ **Work phone:** \_\_\_\_\_ **Cell phone:** \_\_\_\_\_

**Mailing address:** \_\_\_\_\_

**Parent/guardian:** \_\_\_\_\_

**Insurance provider:** \_\_\_\_\_ **Insurance policy #:** \_\_\_\_\_

**Insurance phone number:** \_\_\_\_\_ **Insurance referral submission date:** \_\_\_\_\_

**Subscriber's name:** \_\_\_\_\_ **Subscriber's SSN:** \_\_\_\_\_

**Referring provider:** \_\_\_\_\_ **Contact person:** \_\_\_\_\_

**Office phone:** \_\_\_\_\_ **Office fax:** \_\_\_\_\_

**Primary care physician (if different from above):** \_\_\_\_\_

**Contact person:** \_\_\_\_\_

**Primary care physician phone:** \_\_\_\_\_ **Primary care physician fax:** \_\_\_\_\_

**Sleep Disorders Center Referral Information**

**Reason for referral:** \_\_\_\_\_

**Prior PSG:**  No  Yes **When** \_\_\_\_\_ (please forward copy) **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

**Signs and symptoms:** (check all that apply)

- |   |   |                                  |                                  |   |                                   |
|---|---|----------------------------------|----------------------------------|---|-----------------------------------|
| <input type="checkbox"/> Observed apnea | <input type="checkbox"/> Daytime sleepiness | <input type="checkbox"/> Snoring | <input type="checkbox"/> CHF     | <input type="checkbox"/> Periodic limb movements        | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Restless legs  | <input type="checkbox"/> Morning headaches  | <input type="checkbox"/> COPD    | <input type="checkbox"/> High BP | <input type="checkbox"/> 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:** \_\_\_\_\_

**Sleep Disorders Center Office Use Only**

**Patient MR#:** \_\_\_\_\_  PSG consult  Insomnia consult  Other: \_\_\_\_\_

**Date referral received:** \_\_\_\_\_ **Date sent for verification:** \_\_\_\_\_ **Date verification received:** \_\_\_\_\_

**Referral needed:** Consult  No  Yes **Date sent:** \_\_\_\_\_

PSG  No  Yes **Date sent:** \_\_\_\_\_

**Authorization needed:** Consult  No  Yes **Authorization #:** \_\_\_\_\_

PSG  No  Yes **Authorization #:** \_\_\_\_\_

**Contact #1:** \_\_\_\_\_ **Contact #2:** \_\_\_\_\_ **Letter sent:** \_\_\_\_\_ **Consult appointment date:** \_\_\_\_\_