



Sleep Disorders Center Cheshire Medical Center

Today's Date_____

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
Patient Information	
Patient Name Patient Address Patient Phone # Work Phone # Patient SS#	DOB
Parent/Guardian	Subscriber SS#
Referring Provider Information	PCP Information
Referring MD	PCP Name
Sleep Disorders Center Referral Information	
REASON FOR REFERRAL Physician Connection Line	Phone: 1-(866) 346-2362) 676-4080

 Form Completed by:
 Date:
 Time:
 Phone #_____

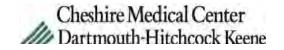




CHESHIRE MEDICAL CENTER PRIOR AUTHORIZATION REFERRAL FORM

Patient Name:	DO	В	HT	WT
IN	DICATIONS/CHIEF COMPLAINTS		Check all th	nat apply
Mood Disorders				
Retrognathia, tonsillar hypertro	ophy, Soft tissue abnormalities			
Mallampati score of 3 or 4				
Class 1: Full visibility of tonsils, Class 2: Visibility of hard and sol Class 3: Soft and hard palate and Class 4: Only Hard Palate visible	t palate, upper portion of tonsils and uvula			
Neuromuscular diseases involvin	g the craniofacial area or upper airw	/ay		
	Co-MORBIDITIES			
Impaired Cognition/Dementia				
Unexplained Pulmonary Hyper	tension			
Moderate to severe congestive	heart failure			
Diagnosed, Significant Cardiac	Arrhythmia not controlled by medic	ation		
Moderate to severe pulmonary	disease			
Neuromuscular Weakness				
Neurodegenerative Disorder				
•	dL in male; >16.5 g/dL in females			
Complex Sleep Disordered Brea				
Stoke, TIA	Date occurred			
Recent change in BMI >5				
Is the patient on PAP therapy?				
Is the patient using a dental dev	/ice?			
SIG	NS AND SYMPTOMS Check all th	at apply		
Observed Apnea	Snoring		ng Headaches	
Restless Legs	Periodic Limb Movements	COPD		
Daytime Sleepiness	Insomnia	CHF		
Frequent unexplained arousals	non restorative sleep	gaspir	ng/choking	
Parasomnia (e.g. sleepwalking)	High BP			
Has the patient had a prior sleep If yes please include the result	test? ts if available or provide the date of te	st, type of pi	YES cocedure and a	NO AHI
Did the patient have a recent T/A If so, date of procedure:_	, UPPP or other ENT surgery?		YES	NO
	ome Sleep Test if one is requested by			NO
	isabled NO YES (explain)		VEG	
Requires Caregiver (Techno)	logist cannot provide nursing care)		YES	NO
Additional Information:				
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Form Completed by:	Date:	11me:	Pho	one #





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THE EPWORTH SLEEPINESS SCALE

Name:

Today's date:_____Your age (years):_____

Your sex (male = M; female = F):_____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = would *never* doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing

Situation	of dozing
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. theater or meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

While these scores are not absolute, a score of 0-10 would indicate that you are less likely to have a problem with sleepiness. A score of 10-14 suggests mild sleepiness. A score above 14 would suggest moderate to severe daytime sleepiness and you should speak to your physician regarding your sleepiness.

Patient signature:	Date: Time:
Form reviewed by:	Phone number: