GEISEL SCHOOL OF MEDICINE AT DARTMOUTH

Cheshire Medical Center
Dartmouth-Hitchcock Keene

Sleep Disorders Center Cheshire Medical Center

Today's Date_____

PHYSICIAN REFERRAL FORM

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# _____
Parent/Guardian _____

DOB _____
Insurance Provider _____
Ins. Phone # _____
Ins. Policy # _____
Ins. Referral Submission date: _____
Subscribers Name_____
Subscriber SS# _____

Referring Provider Information

Referring MD _____
NPI # _____
MD Telephone # _____
MD Fax _____
Contact Person _____

PCP Information

PCP Name _____
NPI # _____
PCP Phone # _____
PCP FAX # _____
Contact Person _____

Sleep Disorders Center Referral Information

REASON FOR REFERRAL _____

Physician Connection Line **Phone: 1-(866) 346-2362**
Fax: (603) 676-4080

Form Completed by: _____ Date: _____Time: _____ Phone #_____

GEISEL SCHOOL OF MEDICINE AT DARTMOUTH

Cheshire Medical Center
Dartmouth-Hitchcock Keene

CHESHIRE MEDICAL CENTER
PRIOR AUTHORIZATION REFERRAL FORM

Patient Name:	**DOB**	**HT**	**WT**

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	
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? YES NO
If yes please include the results if available or provide the date of test, type of procedure and AHI._____

Did the patient have a recent T/A, UPPP or other ENT surgery? YES NO
If so, date of procedure:_____

Is the patient able to perform a Home Sleep Test if one is requested by their insurance? YES NO
If not, why?_____
Physically or Developmentally Disabled NO YES (explain) _____
Requires Caregiver (Technologist cannot provide nursing care) YES NO

Additional Information: _____

Form Completed by: _____ Date: _____Time: _____ Phone #_____

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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	Chance 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: _____**