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: ________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
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Please attach with this form:

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