OSF HealthCare SLEEP MEDICINE REFERRAL FORM

Referral Source Information:		**Note: Scheduling your patient is dependent upon review of the patient's health record.** **Requests for testing must include:** • **Detailed H & P (including underlying diagnosis)** • **Insurance Information with SSN** • **Completed Epworth Sleepiness Scale, BMI and Neck Circumference** **Failure to include this information will delay care.**
☐ Medicare ☐ Medicaid ☐ Other: _____		
Referred By:	Date:	
Physician Practice/Group:		
Office Contact Person:		
Phone:	Fax:	

***Please fax this form and requested information to 309-655-6967 or email to sleep.scheduling@osfhealthcare.org ***

Patient Information:			
Patient Name:	MR#:	DOB:	Gender: ☐ Male ☐ Female
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:	
Height:	Weight:	BMI:	Neck Circumference:

☐ **Referral to Evaluate and Treat** = Review of history & physical to determine if testing is indicated or if a visit with a sleep clinician is required prior to testing. Appropriate testing (in lab PSG, Split or HST as indicated/required) and Titration study will be scheduled as indicated.
Follow-up care for sleep disorders will be provided by a sleep clinician at an OSF Sleep facility.

Note: If your patient is already on therapy for sleep apnea they will need to be evaluated by a sleep physician prior to testing. Mean Sleep Latency Testing (MSLT) and Mean Wakefulness Test (MWT) will also require a visit with the sleep physician prior to testing.

Special Needs/Assistance Required:

☐ Interpreter- Language:	☐ Caregiver needed	☐ Mobility (wheelchair, elevated fall risk)
☐ Incontinence Problems	☐ Seizure Precautions	☐ Psychiatric or behavioral problems that could impact testing

Does patient require oxygen? ☐ Yes ☐ No, If yes; oxygen at a flow rate of _____ lpm. Is oxygen: ☐ Continuous ☐ Nocturnal ☐ PRN

Does patient use a positive airway pressure modality? ☐ Yes ☐ No, If yes answer questions below.

Mode: ☐ CPAP ☐ Bi-level ☐ Bi-level with rate ☐ ASV ☐ Other:

Settings:	Patient interface (please include name and brand):

Indications for sleep study:	**Relevant Medical History**		
☐ Witnessed apneas	☐ Obesity (BMI >30)	☐ Cardiac Arrhythmias (A-Fib, SVT)	☐ ADD/ADHD
☐ Snoring	☐ Hypertension, Uncontrolled	☐ Obesity related Hypoventilation	☐ Diabetes
☐ Choking, gasping during sleep	☐ COPD	☐ Neuromuscular Disorder	☐ Epilepsy
☐ Daytime sleepiness ESS ____	☐ Asthma	☐ Large Tongue	☐ Nocturnal Seizures
☐ Morning Headaches	☐ CHF	☐ Large Uvula	☐ Depression
☐ Irritability/Moodiness	☐ CAD or ☐ MI	☐ Adenotonsillar Hypertrophy	☐ Anxiety
☐ Falling asleep driving or at work	☐ CVA	☐ Retrognathia / Micrognathnia	☐ Rhinitis
☐ Leg movements during sleep	☐ Other:		
☐ Insomnia ☐ Parasomnia	☐ Other:		

Provider Printed Name:	Date:
Provider Signature:	

For Sleep Lab Office Use Only: The patient information, history and indications for sleep study has been reviewed by a Board Certified Sleep Physician with the following recommendations:

☐ Appointment with an OSF Sleep Clinician is required for evaluation prior to testing.

☐ Sleep Study Indicated: ☐ Home Apnea Test ☐ In Lab Polysomnogram ☐ Split Night Polysomnogram ☐ Titration PSG

Additional parameters to be monitored (when indicated):

☐ ETCO2 ☐ TCO2 ☐ Parasomnia Montage ☐ Extended EEG Montage ☐ Epilepsy Montage

Instructions:

Comments (why study is medically indicated):

Board Certified Sleep Specialist: _____ Date: _____

Printed Name: _____