



Sleep Study/Evaluation Referral Form

Portland Office:

11790 SW Barnes Rd, STE 330 Portland, OR 97225
 Phone: (503) 228-4414
 Fax: (503) 228-7293

Astoria Office:

2120 Exchange St, STE 302 Astoria, OR 97103
 Phone: (503) 325-3126
 Fax: (503) 325-4933

PLEASE INCLUDE CHART NOTES, MEDICATION LIST AND FRONT/BACK OF RECENT INSURANCE CARDS

Patient Name:		Date of Birth:	
Home/Work Phone:		Cell Phone:	
Primary Insurance:		Primary Insurance ID:	
Secondary Insurance:		Second Insurance ID:	

MEDICAL HISTORY (a history and physical exam is required)

<u>Suspected Diagnosis:</u>	<u>Signs/Symptoms:</u>	<u>Past Medical History:</u>	<u>Special Needs:</u>
<input type="radio"/> Sleep apnea <input type="radio"/> Restless leg Syndrome <input type="radio"/> Insomnia <input type="radio"/> Narcolepsy	<input type="radio"/> Snoring <input type="radio"/> Witnessed apnea <input type="radio"/> Obesity <input type="radio"/> Daytime Sleepiness	<input type="radio"/> CAD <input type="radio"/> HTN <input type="radio"/> Stroke <input type="radio"/> COPD	<input type="radio"/> Nocturnal O2: _____ L/min <input type="radio"/> Wheelchair

PATIENT IS BEING REFERRED FOR (check only ONE):

Consultation and Management. Visit with a sleep specialist to evaluate and treat patient.

Or, a Direct Sleep Study (Listed below) – In which the Ordering provider is responsible for discussing test results with patient and initiating treatment, if indicated.

- Diagnostic Polysomnogram:** Full night sleep study
- Split Night Polysomnogram:** Full sleep study. First part diagnostic and second part CPAP titration, if criteria is met.
- Home Sleep Study:** Patient is able to cooperate in the self-application and removal of home testing equipment.
- PAP or BiPAP Titration:** Full night sleep study for patients with documented sleep apnea.

***Please include current CPAP/BIPAP pressures and a reason for re-titration (e.g fatigue, weight gain, etc).**

Matrix Titration: This titration uses a Matrix tray to determine whether a patient will be a responder to oral appliance therapy. Patient must bring the Matrix tray to the study as created by his/her dentist.

_____ mm is the Comfortable/Regular bite _____ mm is the Maximum Protrusion

Diagnostic Study w/Oral Appliance: Providing objective information regarding how well an appliance is maintaining a patient's airway.

ORDERING CLINICIAN INFORMATION

Name: _____ Signature: _____

Address: _____ Phone: _____ Fax: _____

Please note that for **pediatric** referrals we ask that you use the Pediatric Patient Referral Form.
 This can be obtained at pacificsleepprogram.com/providers or by contacting our office at 503-228-4414.