Pacific Sleep Program: 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)

Suspected Diagnosis:	**Signs/Symptoms:**	**Past Medical History:**	**Special Needs:**
o Sleep apnea	o Snoring	o CAD	o Nocturnal O2:_____L/min
o Restless leg Syndrome	o Witnessed apnea	o HTN	o Wheelchair
o Insomnia	o Obesity	o Stroke	
o Narcolepsy	o Daytime Sleepiness	o COPD	

PATIENT IS BEING REFERRED FOR (check only ONE):

- o **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.

- o **Diagnostic Polysomnogram**: Full night sleep study
- o **Split Night Polysomnogram**: Full sleep study. First part diagnostic and second part CPAP titration, if criteria is met.
- o **Home Sleep Study**: Patient is able to cooperate in the self-application and removal of home testing equipment.
- o **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).**
- o **Matrix Titration:** This titration uses a Matrx tray to determine whether a patient will be a responder to oral appliance therapy. Patient must bring the Matrx tray to the study as created by his/her dentist.

  _____ **mm is the Comfortable/Regular bite** _____ **mm is the Maximum Protrusion**
- o **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