TRINITAS
Regional Medical Center

REFERRAL FORM FOR SLEEP EVALUATION

MEMBER CENTER

SLEEP DISORDERS CENTER AT TRINITAS REGIONAL MEDICAL CENTER

PATIENT NAME: _____ DATE OF BIRTH: _____

HOME TELEPHONE: _____ CELL NUMBER: _____

SERVICES REQUESTED: (PLEASE COMPLETE EITHER OF THE FOLLOWING SECTIONS)

OR

☐ **SLEEP STUDY ONLY. PLEASE FILL OUT AND FAX THIS H/P FORM TO THE SLEEP CENTER FOR REVIEW BY D'ABSM.**

HISTORY AND PHYSICAL

SLEEP PROBLEMS

Witnessed Apnea
Excessive Daytime Sleepiness
Snoring
Frequent Awakenings
Morning Headaches
Tiredness/Fatigue
Insomnia
Cataplexy
Sleep Walking/Talking
Restless Legs
Sleep Paralysis
Convulsions

MEDICAL CONDITIONS

HTN
CHF
Cardiac Arrthymias
Stroke Seizures
GERD
Diabetes
COPD Asthma
Other: _____
Depression
Thyroid Dysfunction
Obesity

PHYSICAL EXAM

Heart	Normal	Abnormal
Lungs	Normal	Abnormal
Abdomen	Normal	Abnormal
CNS	Normal	Abnormal

HEENT

Nose	Normal	Abnormal
Tongue	Normal	Abnormal
Dentition	Normal	Abnormal
Uvula	Normal	Abnormal
Tonsils	Normal	Abnormal
Soft Palate	Normal	Abnormal

Friedman Scale_____

PRESUMPTIVE DIAGNOSIS

Sleep Apnea
Narcolepsy
PLMD Restless Legs
Nocturnal Seizures
Sleepwalking
Hypersomnia
Insomnia
Other: _____

TYPE OF STUDY

Basic Polysomnogram CPT 95810
CPAP BIPAP Titration CPT 05811
Split Night 95811
MSLT CPT 95805****
MWT CPT 95805****

****Need Sleep Medicine Consultation

ACCREDITED BY THE AMERICAN ACADEMY OF SLEEP MEDICINE