Sleep Center for Adult and Pediatric Patients

UPSTATE
UNIVERSITY HEALTH SYSTEM

Phone: 315.492.5877
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5700 West Genesee Street, Suite 101
Camillus, NY 13031

PATIENT REFERRAL FORM

Request must include a recent H&P or office note demonstrating symptoms and/or complaints

Physician Information:

Physician Name: _____

Specialty: ☐ Other Specialty_____ **(USE OPTION 1)**
Pulmonary, ENT, Neurology, Psychology **(USE OPTION 2)**

Phone: _____ **Fax**: _____

Address: _____

_____ _____/_____/_____
Referring Physician's Signature **Date**

Patient Information:

Patient's Name: _____

Address: _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Date of birth: _____ **Social Security**: _____ - _____ - _____ **Sex:** Male / Female

Primary Insurance Company: _____

ID/Contract#: _____ **Group #:** _____

Insurance Address/Phone: _____

Referral/Authorization #: _____

Secondary Insurance Company: _____

ID/Contract#: _____ **Group #:** _____

Insurance Address/Phone: _____

Referral/Authorization #: _____

OPTION 1:

1. ( ) Request for Sleep Center Physician Consultation and Sleep Study, if indicated

- **Sleep Center physician will initiate management and provide guidelines for ongoing care.**
- **Please provide indication for consultation, recent progress note.**
- **Please provide a current medication list.**

Reason for consultation: _____

_____

==========**OR**==========

OPTION 2:

2. ( ) Direct Referral for Sleep Study Only

- **Only available to ENT, neurology, pulmonary and sleep certified physicians.**
- **Ordering MD will independently manage patient after study.**
- **Please provide a recent progress note and medication list.**

Time of Study: ( ) Nocturnal or ( ) Daytime

Type of Study: ( ) CPSG
( ) CPSG with oral appliance in place
( ) PAP titration
( ) Split apnea/CPAP (will be performed only if meets AASM criteria)
( ) MSLT (Multiple Sleep Latency Test)
( ) MWT (Maintenance of Wakefulness Test)
( ) Seizure protocol

For MSLT/MWT:
( ) Continue all medications
( ) Discontinue medications for _____ days before study
Medications to be held: _____

Patient Symptoms
( ) Snoring
( ) Apnea
( ) Nocturnal choking or gasping
( ) Sleep-related movement disorder
( ) Excessive daytime sleepiness
( ) Other _____

Associated medical condition:
( ) Hypertension
( ) Cardiac arrhythmia
( ) Ischemic heart disease
( ) Congestive heart failure
( ) TIA/Stroke history
( ) Mood disorder
( ) Insomnia
( ) Impaired cognition

Allergies: _____ **Latex Allergy?** YES/NO

Additional Patient Information: (circle) Explain all YES answers

Does patient reside in a group home or assisted living environment? YES/NO
If yes, provide 24 hour/day contact person and phone number: _____
Is patient deaf or blind? YES/NO
Does patient have difficulty communicating or speaking English requiring an interpreter or family member be present? YES/NO
Need help with ambulation? YES/NO
Need help getting in/out of bed? YES/NO
Use an irremovable hair piece? YES/NO
Incontinence or require use of a bedside commode or urinal? YES/NO
Any cultural or religious customs which would interfere with performing a sleep study? YES/NO
UNCONTROLLED seizure disorder, heart failure, coronary disease, or chronic airway obstruction? YES/NO
History of resistant organism cultured from patient? If yes, circle: MRSA VRE Other YES/NO
Does patient have any special needs? Please explain: _____
_____

Please note:

- The patient MUST be able to provide and self-administer all of his/her own medications.
- Nursing care is NOT available in The Sleep Center.
- If necessary, a caregiver may stay with the patient.

Patients cannot be scheduled until this form has been completed and reviewed.