



Appointments: 703-348-7857
301-693-7001
Fax: 703-444-4308
www.SleepHeart.com

Referral Form

Patient Name _____ DOB _____
Phone: Cell _____ Home _____

MEDICAL HISTORY Check all that apply.

Symptoms

- Pre-Operative Screening
- Overweight
- Insomnia
- Nocturia
- Sleepiness / Fatigue
- Concentration / Memory
- Headaches
- TMJ or Teeth Grinding
- Motor Vehicle Accidents

Medical Problems

- Depression
- Anxiety
- ADD / ADHD
- Hypertension
- Diabetes
- Arrhythmia (e.g. A.Fib)
- CAD, MI, or CHF
- Stroke
- Fibromyalgia

Suspected Disorders

- Obstructive Sleep Apnea
- Narcolepsy
- RLS (Restless Leg Syndrome)
- PLMS (Periodic Limb Movements of Sleep)
- Parasomnia (e.g. sleep walking)
- Seizure Disorder
- Other: _____

REFERRAL FOR

- Sleep Specialist Clinic** to evaluate and manage adults or children with sleep disorders that may be psychological, pulmonary or neurological in nature (e.g. insomnia, sleep apnea, and narcolepsy).
- Insomnia CBT Clinic** to help patients learn to sleep well without medications.
- CPAP Therapist Clinic** to help patients become comfortable with using CPAP. Program includes mask fitting, CPAP classes, support groups, and other assistance to succeed with CPAP.

Sleep Laboratory to diagnose children or adults with sleep disorders. All sensors required by the American Academy of Sleep Medicine are used during studies in addition to capnography and other specialized sensors when requested.

- Diagnostic PSG only
 - Diagnostic PSG followed by MSLT
 - PAP titration
 - Diagnostic PSG to assess sleep quality on current PAP settings
- additional comments: _____

Please feel free to call to discuss specific needs or concerns.

REFERRING / ORDERING PROVIDER

Printed Name: _____ Phone: _____
Signature: _____ Date: _____

Please **fax to 703-444-4308** and the patient will be contacted to schedule an appointment.
Please call 703-348-7857 to directly schedule an appointment.