



Appointments: 877-411-DOZE
Office: 703-348-7857
Fax: 877-511-DOZE
www.SleepHeart.com

REFERRAL FORM

Please fax to 877-511-3693 and the patient will be contacted to schedule an appointment.
Please call 703-348-7857 to directly schedule an appointment or for additional information.

PATIENT INFORMATION

Name Date of Birth Email
Phone: Cell Home Work

MEDICAL HISTORY A recent office note is helpful. Check all that apply.

Suspected Disorders

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

Symptoms

- Daytime Sleepiness
Snoring/gasping/choking
Witnessed apneas
Difficulty falling asleep
Disturbed sleep
Leg movements
Headaches
Motor Vehicle Accidents

Signs / Medical Problems

- Overweight
Hypertension
Arrhythmia (e.g. Atrial Fib)
CAD / MI
CHF
Stroke
ADHD
Depression
Kidney Disease / Dialysis

REFERRAL FOR:

- Consultation and Management including visit with a sleep specialist to evaluate and treat patient.
Diagnostic Sleep Study including full night polysomnogram to evaluate patients for sleep apnea (OSA) or to assess adequacy of current CPAP treatment pressure.
Diagnostic Sleep Study with MSLT including full night polysomnography (PSG) followed by daytime multiple sleep latency test (MSLT) to evaluate excessive sleepiness.
CPAP Therapy Program including visit with a CPAP therapist followed by CPAP habituation, counseling, mask fitting, CPAP classes, support groups, and other assistance to succeed with CPAP

REFERRING PHYSICIAN Self-Referral

Name:
Phone:
Fax:
Email:

PRIMARY CARE PHYSICIAN same as Referring

Name:
Phone:
Fax:
Email:

Specific requests or comments (if any):

Referring Physician Signature: Date: