

160 Allen Street  
 Rutland, VT 05701

Phone: 802.747.3792 Fax: 802.772.1941

**SLEEP CENTER REFERRAL FORM**

 Dear Doctor: Thank you for referring your patient for a sleep study evaluation. In order to provide the best possible service to you and your patient, please fax this referral form with **Current Office Notes** to the Rutland Regional Medical Center Sleep Center at 802.772.1941.

Patient Name:		DOB:	Age:
<input type="radio"/> Male <input type="radio"/> Female	Height:	Weight:	Parent/Guardian Name:
Phone -- Home:		Work:	Alternate:
Patient Address:			
Primary Insurance Provider:		Policy #:	Group #:
Secondary Insurance Provider:		Policy #:	Group #:
PCP/Other Treating Physician(s):			
Referring Provider Name:			
Office Address for Test Results:			
Office Numbers -- Phone:		Fax:	
Type of Study Requested: <input type="checkbox"/> Initial Sleep Study <input type="checkbox"/> Home Sleep Test (if qualifies) <input type="checkbox"/> Patient had initial sleep study, requires CPAP titration <input type="checkbox"/> PSG/MSLT for suspected narcolepsy <input type="checkbox"/> Maintenance of Wakefulness Test (MWT)			
Previous Sleep Study? If yes, where:		When:	
Sleep History/Symptoms (check all appropriate): <input type="radio"/> Excessive daytime sleepiness <input type="radio"/> Wakes up choking/gasping <input type="radio"/> Snoring <input type="radio"/> Witnessed apnea <input type="radio"/> Restlessness <input type="radio"/> Nonrestorative sleep <input type="radio"/> Nocturnal Dyspnea <input type="radio"/> Leg movements <input type="radio"/> Acting out dreams <input type="radio"/> Cataplexy <input type="radio"/> Sleep walking <input type="radio"/> Sleep paralysis <input type="radio"/> Insomnia			
Relevant Medical History (check all appropriate): <input type="radio"/> OSA <input type="radio"/> UARS <input type="radio"/> Central Sleep Apnea <input type="radio"/> CAD <input type="radio"/> Stroke <input type="radio"/> Arrhythmia <input type="radio"/> Hypertension <input type="radio"/> CHF <input type="radio"/> Obesity <input type="radio"/> Diabetes <input type="radio"/> Anxiety disorder <input type="radio"/> Depression <input type="radio"/> Pulmonary disease <input type="radio"/> Status Post Surgery for OSA <input type="radio"/> Planned ENT Surgery <input type="radio"/> Seizure Disorder			
Latex Allergy: <input type="checkbox"/> Yes <input type="checkbox"/> No Allergies: _____ Other: _____			
Special Needs/Requirements: <input type="radio"/> Caretaker/guardian <input type="radio"/> Claustrophobia <input type="radio"/> Hospital bed/recliner <input type="radio"/> Oxygen <input type="radio"/> Wheelchair <input type="radio"/> Shift Worker <input type="radio"/> Parent/Guardian for Pediatric Sleep Study Other: _____			
<b>I agree to review the results of the sleep study with my patient .</b>			
I request that Sleep Center the forward this referral to Vermont Sleep Medicine to set up a long-term follow-up appointment with Dr. Collins: <input type="radio"/> Yes <input type="radio"/> No			
Physician's Signature: _____		Date: _____	

**THE SLEEP CENTER REFERRAL FORM**
**PATIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Part I: Please answer the following questions:**

1. Do you snore?
2. Do you suffer with morning sluggishness?
3. Do you wake up tired?
4. Do you gasp or choke during sleep?
5. Has anyone ever said that you stop breathing at night?
6. Do you toss and turn excessively while sleeping?
7. What is your normal bedtime? (Give range if necessary)
8. What time do you normally wake up from your sleep period for the day?
9. How long does it take you to fall asleep after you lie down and turn off the lights?
10. How many times do you wake up during your sleep period before it's time to rise?
11. What is your average number of sleeping hours each night?

**Part II (Epworth Sleepiness Scale)**

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Choose the most appropriate number for each situation:

0 = Would never fall asleep    1 = Slight chance of dozing    2 = Moderate chance of dozing    3 = High chance of dozing

Situation	Chance of Dozing			
	0	1	2	3
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting in a public place (i.e., theater or a meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3
	<b>TOTAL</b>			