Rutland Regional Medical Center

Center for Sleep Disorders

160 Allen Street
Rutland, VT 05701

802.747.3792
802.772.1941 fax

CENTER FOR SLEEP DISORDERS REFERRAL FORM

Dear Provider: 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 Rutland Regional Medical Center Sleep Center at 802.772.1941.

Patient Name: DOB: Age:

○ Male ○ 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 Provider (s):

Referring Provider Name:

Office Address for Test Results:

Office Numbers ~~ Phone: Fax:

Type of Service Requested: ☐ Sleep consult ☐ Insomnia Program Referral

Previous Sleep Study? If yes, where: _____ When: _____

Sleep History/Symptoms (check all appropriate): ○ Excessive daytime sleepiness ○ Wakes up choking/gasping ○ Snoring ○ Witnessed apnea ○ Restlessness ○ Nonrestorative sleep ○ Nocturnal Dyspnea ○ Leg movements ○ Acting out dreams ○ Cataplexy ○ Sleep walking ○ Sleep paralysis ○ Insomnia

Relevant Medical History (check all appropriate): ○ OSA ○ UARS ○ Central Sleep Apnea ○ CAD ○ Stroke ○ Arrhythmia ○ Hypertension ○ CHF ○ Obesity ○ Diabetes ○ Anxiety disorder ○ Depression ○ Pulmonary disease ○ S/P Surgery for OSA ○ Planned ENT Surgery ○ Seizure Disorder

Latex Allergy: ☐ Yes ☐ No Allergies: _____ Other: _____

Special Needs/Requirements: ○ Caretaker/guardian ○ Claustrophobia ○ Hospital bed/recliner ○ Oxygen ○ Wheelchair ○ Shift Worker ○ Parent/Guardian for Pediatric Sleep Study Other: _____

I agree to review the results of the sleep study with my patient.

Provider's Signature: _____ Date/Time: _____

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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 is 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			
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
			TOTAL	