



6804

Sleep Disorder Center Referral Form

- Hartford Hospital – 11th floor, Center building
- Bloomfield – 533 Cottage Grove Road

Please fax to (860) 545-5080. Phone: (860) 545-2996

Please Print Patient Information:

Date: _____

Name _____ DOB: _____ Gender: F M
Last First

Address _____ City _____ State _____ Zip _____

Phones: Home _____ Work _____ Cell _____
Available Time Available Time Available Time

Emergency Contact _____ Phone _____

Insurance _____ Secondary Insurance _____
 ID # _____ ID# _____
 Pre-Authorization No. _____ Pre-Authorization No. _____

Ordering Physician _____ Phone _____ Fax _____

Physician Signature: _____ Copy to: _____

STUDY TO BE DONE: "Please Fax a copy of insurance card or insurance demographics with this form".

<input type="checkbox"/> Consultation with Comprehensive Mgmt. (95810/95811)	Patient consult with sleep specialist which will include sleep testing, ordering of equipment , and follow up as needed.
<input type="checkbox"/> Sleep Testing only (95810/95811)	Overnight diagnostic Polysomnography for evaluation of sleep apnea. Split night study will be performed if patient meets protocol. CPAP/BiLevel titration study will be ordered by sleep specialist if indicated.
<input type="checkbox"/> CPAP/Bilevel Titration study (95811)	Patient must have had sleep study with diagnosis of OSA within the last year and requires follow-up Titration study.
<input type="checkbox"/> Multiple Sleep Latency Test (MSLT) (95805)	Daytime nap study following full night diagnostic PSG to diagnose narcolepsy or excessive sleepiness.
<input type="checkbox"/> Maintenance of Wakefulness Test (MWT) (95805)	Daytime study following full night diagnostic PSG to evaluate ability of patient to stay awake.

Suspected Disorders:

Obstructive Sleep Apnea Narcolepsy
 Periodic Limb Movement Disorder Nocturnal Seizures/Parasomnias
 Insomnia Complex Sleep Apnea Other: _____

Sleep Related Complaints:

Snoring Difficulty Initiating and Maintaining Sleep Restless leg sensations or kicking
 Witnessed Apnea Daytime Fatigue Seizures
 Excessive Sleepiness Irritability Abnormal behavior during sleep
 Frequent Nocturnal Arousals Other _____

Special Needs:

Assistance in/out of bed Oxygen _____ LPM
 Incontinence Dementia
 Needs interpreter _____ Aide required at home

Patient History: (Please attach a copy of Problem List and Medication List)

Diabetes Stroke Height _____
 Hypertension Pulmonary Hypertension Weight _____
 Heart Disease COPD
 Heart Failure Sleep Center MD Review _____ Date _____