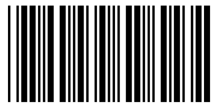
Hartford Hospital
Connect to healthier.


6804

Sleep Disorder Center Referral Form

❒ Wethersfield - 1260 Silas Deane Highway Suite 101
❒ Bloomfield – 533 Cottage Grove Road

Please fax to (860) 545-5080. Phone: (860) 696-2820

Please Print Patient Information: Med Record # **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# ______________________________

Ordering Physician ______________________________ Phone ______________ Fax ______________

Physician Signature:______________________________ Date:______________Time:______________

STUDY TO BE DONE: ***PLEASE FAX A COPY OF INSURANCE CARD OR INSURANCE DEMOGRAPHICS WITH THIS FORM.***

Study	Description
❒ Consultation with Comprehensive Mgmt. *(95810/95811)*	Patient consult with sleep specialist which will include **sleep testing**, **ordering of equipment**, and follow up as needed.
❒ 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. *Home Sleep Study (95806) will be performed if patient does not meet insurance criteria for attended study (95810)*
❒ CPAP/Bilevel Titration Study *(95811)*	Patient must have had sleep study with diagnosis of OSA and requires follow-up Titration study.
❒ Multiple Sleep Latency Test (MSLT) *(95805)*	Daytime nap study following full night diagnostic PSG to diagnose narcolepsy or excessive sleepiness.
❒ Maintenance of Wakefulness Test (MWT) *(95805)*	Daytime test used to objectively measure the sleepiness and wakefulness of patients in whom the inability to remain awake constitutes a safety issue, or to assess response to treatment in patients with narcolepsy or idiopathic Hypersomnia.
❒ Home Sleep Apnea Testing (HSAT) *(95806)*	Patient education and device set up occurs at sleep center. Patient returns device the following day. Not appropriate if patient has significant comorbidities, other sleep disorders, or is unable to apply the device.

REASON FOR TESTING:

❒ Sleep Apnea, suspected *(G47.30)*
❒ Obstructive Sleep Apnea, previously diagnosed *(G47.33)*
❒ Periodic Limb Movement Disorder *(G47.61)*
❒ Central Sleep Apnea, primary *(G47.31)*
❒ Narcolepsy with Cataplexy *(G47.411)*
❒ Narcolepsy without Cataplexy *(G47.419)*
❒ Insomnia, unspecified *(G47.00)*
❒ Parasomnias, unspecified *(G47.50)*
❒ Seizures, unspecified *(G40.89)*
❒ Other ______________

SLEEP RELATED COMPLAINTS:

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

SPECIAL NEEDS:

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

PATIENT HISTORY: ***PLEASE ATTACH A COPY OF PROBLEM AND MEDICATION LIST***

❒ Diabetes
❒ Hypertension
❒ Heart Disease
❒ Heart Failure
❒ Stroke
❒ Pulmonary Hypertension
❒ COPD (stage______)
❒ Neuromuscular
❒ Seizure
❒ Other

Height __________
Weight __________