Hartford Hospital
A Hartford HealthCare Partner

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 _____
ID# _____

Secondary Insurance _____
ID# _____

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".***

❒ 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.
❒ 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.
❒ Home Sleep Testing (HST) *(95806)*	Patient comes to Sleep Center for set up and instruction. Device is returned the following day. Not appropriate if patient has significant comorbidities, other sleep disorders, or is unable to apply the device.

Suspected Disorders:

❒ Obstructive Sleep Apnea *(G47.33)*
❒ Periodic Limb Movement Disorder *(G47.61)*
❒ Central Sleep Apnea *(G47.31)*
❒ Narcolepsy *(G47.419)*
❒ Insomnia with Sleep Apnea, unspecified *(G47.30)*
❒ Parasomnias *(G47.50)*
❒ Nocturnal Seizures
❒ Other _____

Sleep Related Complaints:

❒ Snoring
❒ Witnessed Apnea
❒ Excessive Sleepiness
❒ Frequent Nocturnal Arousals
❒ Difficulty Initiating and Maintaining Sleep
❒ Daytime Fatigue
❒ Irritability
❒ 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 List and Medication List)*

❒ Diabetes
❒ Hypertension
❒ Heart Disease
❒ Heart Failure
❒ Stroke
❒ Pulmonary Hypertension
❒ COPD

Height _____
Weight _____

Sleep Center MD Review _____ **Date** _____ **Time** _____