1960 FAMILY PRACTICE

CENTER FOR SLEEP DISORDERS
5039 FM 2920 | Spring, Texas 77388 (Sleep Center)
phone: (281) 453-7139 | fax: (281) 453-7121

REFERRAL | ORDER FORM

Patient Name: ____________________ Date: ____________

Phone: ____________________ DOB: ____________

QUESTIONNAIRE:

How likely are you to doze off or fall asleep in the situations described below, (not just feeling tired). Even if you have not done some of these things recently, try to determine how they would have affected you.

Situation:	Chance of dozing: never	slight	moderate	high
Sitting and reading				
Watching TV				
Sitting, inactive in a public space (eg: theater or a meeting)				
As a passenger in a car for an hour without a break				
Lying down to rest in the afternoon when circumstances permit				
Sitting and talking to someone				
Sitting quietly after a lunch without alcohol				
In a car, while stopped for a few minutes in the traffic				
Total Check Marks				
(Points per check mark)	0	1	2	3

Total Score: ____

Score:	0-10	10-12	12-24
	Normal	Borderline	Abnormal

Please circle your answer:
Do You snore?Yes or No
Do you wake up tired?Yes or No
Do you feel tired most of the day? Yes or No

Do you experience involuntary leg movements/leg jerking?(Please circle one) Frequently Sometimes Never

DIAGNOSIS:

- ☐ G47.33-Obstructive Sleep Apnea
- ☐ G47.30- Sleep apnea, unspecified
- ☐ G25.3 - Myoclonus (RLS)
- ☐ G47.419 - Narcolepsy
- ☐ G47.00 - Insomnia
- ☐ G47.14 - Hypersomnia
- ☐ G47.9 - Sleep disturbance
- ☐ F51.8 - Nocturnal seizures/parasomnias
- ☐ G47.20 - Disruption assoc. w/sleep stages or arousal frm sleep
- ☐ G47.8 - Dysfunction assoc. w/sleep stages or arousal frm sleep

Other Medical Problems:____________________

- ☐ I50.9- Congestive Heart Failure
- ☐ I97.3 - Hypertension
- ☐ Z68.42 -BMI >45 (45-49.9)
- ☐ J96.90- Acute respiratory failure
- ☐ E11.9 - Diabetes w/o mention of complication

REFERRAL FOR:

- ☐ Sleep study, treatment and follow up consultation
- ☐ Sleep Home Monitor (Aetna)

SELECT SLEEP STUDY TO BE PERFORMED:

- ☐ PSG/CPAP- 2 night protocol if criteria met.
- ☐ Split Night Study
- ☐ CPAP Titration Only
- ☐ Polysomnogram Only
- ☐ PSG/Multiple Sleep Latency
- ☐ PSG/Maintenance of Wakefulness

REFERRING/ORDERING PHYSICIAN INFORMATION:

PHYSICIANS NAME ____________________ PHYSICIANS SIGNATURE ____________________

PHONE ____________________ FAX ____________________

FAX ORDER TO: (281) 453-7121

Scheduled by: Appt Date: Appt Time:

SC Health Care is a non-network company. Plans without these benefits will be referred to a network company.