ELITE SLEEP

Physician Referral Form

Phone 425.377.9988 | Fax 425.880.5815

Date: _____

Patient's Name: _____ DOB: _____

Male/Female: _____ Patient's Phone: _____ Email _____

Insurance Company: _____ Insurance Phone: _____

Services Ordered:

- □ Consultation/Exam (Testing as needed)
- □ HST (Home Sleep Test)
- □ NPSG (Overnight Sleep Study)
- □ Split Study (50/50 Overnight Sleep Study with CPAP Titration) **if AHI is greater than**_____
- □ CPAP Titration
- □ BiPAP Titration
- □ ASV Titration
- □ OAT Titration
- □ NPSG with MSLT to follow (Overnight Sleep Study with Daytime Nap following)
- □ **Add oxygen if SAO2 is below** _____**%**

History & Physical:

- □ Snoring
- □ Apnea witnessed by family member or bed partner
- □ Excessive daytime somnolence; **ESS Score:** _____
- □ Leg twitching
- □ Seizures
- □ Frequent awakenings
- □ Nasal Congestion
- □ Obesity
- □ Deviated Septum
- □ COPD/Asthma
- □ Hypertension
- □ Cardiac Abnormalities
- □ Other Neurological disorders
- □ Other Pulmonary disorders
- □ Other: _____

Physician's signature: _____

Physician's Name: _____

Physician's mailing address: _____

Physician's Phone: _____ Fax: _____

Thank you for your referral, we will contact patients within 2 business days!