



**St. Joseph Sleep Center**  
**Referral Form**

**Phone: 979-774-2936 • Fax: 979-774-5385**

The following medical information is necessary prior to initiating this sleep study. Please complete and fax to us along with current pertinent clinical information (i.e. recent physical history, recent progress/consultation notes) and the *patient's insurance demographics*.

- |   |  |
|---|--|
| <input type="checkbox"/> Snoring                            | <input type="checkbox"/> Choking or gasping at night     |
| <input type="checkbox"/> Depression or other Mood disorder  | <input type="checkbox"/> Drowsy driving                  |
| <input type="checkbox"/> High blood pressure (HTN)          | <input type="checkbox"/> Morning or frequent headaches   |
| <input type="checkbox"/> Cardiac Disease                    | <input type="checkbox"/> Night Terrors                   |
| <input type="checkbox"/> Diabetes                           | <input type="checkbox"/> Sleep Walking/Talking/Eating    |
| <input type="checkbox"/> Leg or arm jerks/Movement at night | <input type="checkbox"/> Unable to sleep on back or flat |
| <input type="checkbox"/> Insomnia (trouble sleeping)        | <input type="checkbox"/> Abnormal Behavior _____         |
| <input type="checkbox"/> Witnessed Apnea                    | <input type="checkbox"/> Other: _____                    |

**Required by Medicare and Insurance:** Pt's Epworth Scale Number: \_\_\_\_\_ or  
Pt's Neck Circumference: \_\_\_\_\_ inches and Pt's BMI: \_\_\_\_\_

**Patient's Name:** \_\_\_\_\_ SS# \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  Male  Female  
(Required) (Required) (optional)

Daytime phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_

\_\_\_\_\_ TX. Zip Code \_\_\_\_\_

**After completing the top section of this form, please leave it with your physician to complete the section below so a sleep study may be scheduled.**

Diagnosis: \_\_\_\_\_

- Order:  Routine/Split Sleep Study  All night PAP Titration  
 Re-titration / re-evaluation of pressure  Sleep Study followed by MSLT  
 Use Seizure Montage with study  Sleep Study followed by MWT  
 Return for Auto-SV titration

Order Clarification/ Extra Instructions: \_\_\_\_\_

Would you like the patient to follow up with our Sleep Specialist?  YES  NO

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
(Please Print) Fax: \_\_\_\_\_

Physician Signature: (No stamps) \_\_\_\_\_ Date: \_\_\_\_\_

*In signing this form I am stating that I have seen the patient in my office recently prior to ordering this test.*

**Sleep Study Information: To Be Completed by SJ Sleep Center**

**Non-Accepted Criterion:** (Each case reviewed individually that excludes a patient for a sleep study(ies) based on Medical Director, staff physician and/or Sleep Center guidelines.)  Incomplete/insufficient pt information

Unstable Medical Condition  Severe Insomnia  Severely Handicapped  Aggressive Behavior(s)  Financial

Other: (Sleep Center cannot accommodate patient.) Please Explain: \_\_\_\_\_

**Medical Director Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_