National Jewish Health®

# Sleep Center Referral Form

Phone: 303-270-2708 Fax: 303-270-2109

**NPI: 1326015777**

**Main Campus - *Clinic & Testing***
1400 Jackson St.
Denver, CO 80206

**Highlands Ranch - *Clinic Only***
8671 S. Quebec St., Ste. 120
Highlands Ranch, CO 80130

## PATIENT INFORMATION

Last Name _____First Name_____MI_____Gender ❑ M ❑ F

DOB_____SSN_____Marital Status ❑ S ❑ M ❑ D ❑ W

Street Address _____Apt/PO_____City_____State_____Zip_____

Phone: Home_____Work _____Cell _____

## PRIMARY INSURANCE

Company_____ID#_____Group_____

Address_____Phone_____

Subscriber_____Guarantor_____DOB_____

Employer_____

## THIS PATIENT IS BEING REFERRED FOR: (Please check all that apply.)

❑ Sleep Consultation — Sleep Specialist Consultation for evaluation, diagnostic testing and treatment.

❑ Sleep Study *Baseline only, Baseline with PAP, PAP Titration, or HST (Home Sleep Testing)*

❑ Multiple Sleep Latency Test following Overnight Sleep Study

❑ Maintenance of Wakefulness Test

❑ Insomnia Consultation (See below.)

*All testing will adhere to American Academy of Sleep Medicine Practice Parameters. For medical documentation and to satisfy insurance guidelines for reimbursement, adequate baseline data and sleep time will be collected before attempting treatment intervention. Split-night studies will be performed whenever appropriate.*

## SUSPECTED DISORDERS AND RELEVANT MEDICAL HISTORY: (Check all that apply and include clinic notes.)

❑ Obstructive Sleep Apnea
❑ Insomnia
❑ Narcolepsy
❑ Periodic Limb Movements (PLMs)
❑ Parasomnias/Nocturnal Seizures
❑ Central Sleep Apnea
❑ Cardiac Conditions
❑ Neurologic Disorder
❑ COPD
❑ Morning Headache
❑ Daytime Fatigue
❑ Snoring

Prior Sleep Study:
❑ in lab PSG Date_____
❑ HST Date_____

If referring for insomnia: Does the patient have any comorbid psychiatric conditions? ❑ Yes ❑ No

Does the patient have sleep apnea or other sleep related breathing disorder? ❑ Yes ❑ No

Primary Care Physician_____Phone_____Fax_____

Referring Physician_____Phone_____Fax_____
*(Print Name)* *(Reports will be sent here)*

Address_____

Signature_____Date_____NPI#_____

**Complete Epworth scale on back side of page. Fax both sides of sheet to 303-270-2109.**
**INCLUDE DOCUMENTATION OF FACE TO FACE VISIT STATING THE REASON FOR A SLEEP STUDY.**
**Please provide medication list.**

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# Epworth Sleepiness Scale

Last Name _____First Name_____DOB_____

How Likely are you to doze off or fall asleep in the following situations?
This refers to the usual way of life in recent times.

If you have not done some of these things recently, estimate how you might have reacted.

0-would never doze
1-slight chance of dozing
2-moderate chance of dozing
3-high chance of dozing

**Chance of Dozing Score**

_____ Sitting and Reading
_____ Watching TV
_____ Sitting, inactive in a public place (e.g. a theatre 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 traffic

_____ **Total**

Reference: Johns MW. A new method for measuring daytime sleepiness: the Epworth sleepiness scale. Sleep. 1991 Dec; 14(6):540-5.

**Complete Epworth Scale above. Fax both sides of sheet to 303.270.2109**