ADVANCED RESPIRATORY & SLEEP MEDICINE, INC.
SHARAD K. DASS, MD, FCCP
MEDICAL DIRECTOR, SLEEP WELL MEDICAL CLINIC
PULMONARY & CRITICAL CARE MEDICINE

Referral Form

Fax: 408-993-1521
Tel: 408-993-1500
E-mail: sleepwell202@sbcglobal.net

Patient Name: _____ Date: _____

Address: _____City: _____ State: _____ Zip code: _____

DOB: _____ Sex: M / F

Telephones: Home: _____ Work: _____ Cell: _____

PRIMARY INSURANCE: _____

☐ SLEEP CONSULTATION

Please select one or more of the following:

☐ **DIAGNOSTIC POLYSOMNOGRAM *(PSG)***
A sleep study using EEG, EOG, EMG for sleep
Staging – plus 4 or more additional parameters of sleep such as EKG, airflow, respiratory effort, oximetry and body position.
Attended by a technologist.

☐ **SPLIT-NIGHT *(Diagnostic & Treatment)***
Polysomnogram with CPAP or BI-LEVEL therapy. Same as above except nasal CPAP or BI-LEVEL therapy is used after a baseline recording. Attended by a technologist.

(If Split-Night criteria are not met, a Diagnostic PSG will be performed)

☐ **TITRATION STUDY *(CPAP OR BI-LEVEL)***
Therapy with all night Polysomnogram CPAP or BI-LEVEL therapy is initiated at the beginning of the night to determine treatment pressure.
Attended by a technologist.

☐ **PORTABLE HOME SLEEP STUDY**
A sleep study performed at the patient's home.
(Not as comprehensive as an Attended Diagnostic PSG)

☐ **MULTIPLE SLEEP LATENCY TEST *(MSLT)***
A series of nap studies performed and generally preceded by a polysomnogram for the objective evaluation of daytime sleepiness or suspected Narcolepsy;
Attended by a technologist.

☐ **MAINTENANCE OF AWAKEFULNESS TEST *(MWT)***
A series of nap studies that are performed primarily during the day following the patient's sleep study. This is a standardized test to justify their level of alertness/wakefulness:
Attended by a technologist.

☐ **OVERNIGHT OXIMETRY STUDY**
A quick screening tool to monitor blood oxygen saturations & heart rate.

☐ PULMONARY CONSULTATION

Please check all that apply.

☐ Asthma ☐ Bronchiectasis ☐ COPD ☐ Cough ☐ Dyspnea ☐ Interstitial Lung Disease ☐ Lung Cancer/Nodule
☐ Lung Volume Reduction Surgery –pre/post ☐ Pulmonary Arterial Hypertension ☐ Spirometry
☐ Other: _____

☐ CPAP SERVICES/SUPPLIES

☐ **CPAP** Pressure: _____cmH2O
CFLEX /EPR of _____

☐ **APAP** Pressure Range: _____ to _____ cmH2O
AFLEX/EPR of _____

☐ **BI-PAP** Pressure: _____ IPAP _____ EPAP
BiFLEX/EPR of _____

☐ HOME OXYGEN @: _____LPM ☐ Nocturnal ☐ Continuous

☐ SUPPLIES

☐ Nasal Mask ☐ Full Face Mask ☐ Nasal Pillows ☐ Headgear
☐ Chinstrap ☐ Filters ☐ Tubing ☐ Chinstrap ☐ Tubing Wrap
☐ Re-instructions ☐ Pressure Change ☐ Battery Pack
☐ Heated Humidifier
☐ Other_____

Referring Physician Information

Specialty: ☐ Family Practice ☐ Internal Medicine ☐ Pulmonary ☐ Cardiology ☐ ENT ☐ Nephrology ☐ Allergy & Asthma
☐ Psychiatry ☐ Neurology ☐ Other _____

Physician Name: _____ Tel: _____ Fax: _____

Address: _____ City:_____ State:_____ Zip:_____

Signature:

_____