Richmond University Medical Center

355 Bard Ave, Staten Island, NY 10310 • t: 718-818-SNOR • f: 718-818-1298

SDI

SLEEP DISORDERS INSTITUTE

PATIENT INFORMATION

PATIENT NAME _____ DATE OF BIRTH ___/___/___

ADDRESS _____

HOME _____ MOBILE _____ WORK _____

INSURANCE CARRIER _____ ID NUMBER _____

TYPE OF VISIT / TEST REQUESTED

☐ **I request that the visit or procedure be determined by a physician at the Sleep Disorders Institute.**

☐ Sleep test only
(Sleep specialist consult notes attached)

☐ Initial Consult
☐ Follow-Up Visit
☐ Nocturnal Polysomnogram
☐ Nasal CPAP Titration

☐ Unattended In-Home Testing
(for R/O OSA only & pending insurance approval)
☐ Split Night
☐ Multiple Sleep Latency Test
☐ Maintenance of Wakefulness Test (MWT)

PATIENT REFERRED TO RULE OUT OR CONFIRM THE FOLLOWING

☐ Sleep Apnea ☐ Daytime Sleepiness ☐ Periodic Limb Movement Disorder
☐ Insomnia ☐ Restless Legs ☐ Narcolepsy ☐ Other _____

PATIENT HISTORY

Snoring..... ☐ Yes ☐ No
Gasping or choking during sleep..... ☐ Yes ☐ No
Apneic events witnessed by bed partner..... ☐ Yes ☐ No
Discomfort or restlessness of lower limbs before or during the sleep period..... ☐ Yes ☐ No
Twitching, jerking, or kicking of lower limbs before or during the sleep period..... ☐ Yes ☐ No
Daytime sleepiness or fatigue..... ☐ Yes ☐ No
Previous diagnosis of OSA?..... ☐ Yes ☐ No
If yes, is patient on CPAP?..... ☐ Yes ☐ No
If on CPAP, at what pressure?..... _____
Has upper airway surgery been performed?..... ☐ Yes ☐ No
Is this request for a sleep study for pre-operative evaluation prior to bariatric surgery?..... ☐ Yes ☐ No
To help with scheduling, when do you plan to have a follow-up appointment with this patient? _____
Height _____ ft. _____ in. Weight _____ lbs. Blood Pressure _____ /_____
Medical Conditions (include recent surgeries) _____
Current Medications _____
Allergies _____
Is the patient a commercial driver?..... ☐ Yes ☐ No
Is assistance required for language translation, ambulation, toileting, or other activities? If yes, please explain: _____

REFERRING PHYSICIAN

NAME _____ TELEPHONE _____

SPECIALTY _____ REFERRAL DATE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ NPI# _____

SIGNATURE _____ FAX _____ E-MAIL _____

REPORT PREFERENCES

☐ Call with test results prior to issuance of report

Send report by ☐ Mail ☐ Fax

Has this patient been to the Sleep Disorders Institute before?

☐ Yes ☐ No If a previous sleep study has been performed at another center, please send a copy of the report

REQUEST FOR CLINICAL POLYSOMNOGRAPHY - Please complete this form and return by fax to 718-818-1298. The Institute's Sleep Care Specialist will contact the patient to schedule tests that you have ordered. This form is not an insurance referral. Your patient may need to contact his/her primary care physician to obtain a valid insurance referral.