



**SLEEP DISORDERS CENTER - PHYSICIAN REFERRAL FORM**

Thank you for referring your patient to the Sleep Disorders Center. In addition to filling out the patient information section, please remember to mark which service to perform. The physician signature line located at the bottom must also be signed including the date and time. Please call us at (831) 649-7210 with any questions.

Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Requesting Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Mark the service to perform:**  Sleep study only  Sleep study and sleep medicine consultation  
 Sleep medicine consultation only

**Check all that apply:**

- |   |  |
|---|--|
| <input type="checkbox"/> Daytime sleepiness (hypersomnia)               | <input type="checkbox"/> Difficulty falling/staying asleep   |
| <input type="checkbox"/> Falling asleep while driving                   | <input type="checkbox"/> Chronic pain                        |
| <input type="checkbox"/> Witnessed apnea                                | <input type="checkbox"/> Cataplexy                           |
| <input type="checkbox"/> Loud snoring                                   | <input type="checkbox"/> Sleep paralysis                     |
| <input type="checkbox"/> Hypertension                                   | <input type="checkbox"/> Hypnagogic hallucinations           |
| <input type="checkbox"/> Cardiac arrhythmia                             | <input type="checkbox"/> Nocturnal seizures                  |
| <input type="checkbox"/> Non-insulin requiring diabetes                 | <input type="checkbox"/> Restless legs                       |
| <input type="checkbox"/> Insulin dependent diabetes                     | <input type="checkbox"/> Morbid obesity: Ht. _____ Wt. _____ |
| <input type="checkbox"/> History of myocardial infarction               | <input type="checkbox"/> Requires walker                     |
| <input type="checkbox"/> History of stroke                              | <input type="checkbox"/> Requires wheelchair                 |
| <input type="checkbox"/> Nocturia                                       | <input type="checkbox"/> Incontinent                         |
| <input type="checkbox"/> Morning headaches                              | <input type="checkbox"/> Hearing impaired                    |
| <input type="checkbox"/> Night sweats                                   | <input type="checkbox"/> Visually impaired                   |
| <input type="checkbox"/> Postop UP3-GGA-MMA                             | <input type="checkbox"/> Caretaker recommended               |
| <input type="checkbox"/> Oral appliance evaluation                      | <input type="checkbox"/> Non - English speaking              |
| <input type="checkbox"/> Nocturnal reflux                               | (language spoken): _____                                     |
| <input type="checkbox"/> Cognitively impaired (please elaborate): _____ |  |
| <input type="checkbox"/> Physically impaired (please elaborate): _____  |  |

**Clinical evaluation:**

As an accredited American Academy of Sleep Medicine Sleep Disorders Center, we encourage clinical evaluation by a physician experienced in the management of sleep disorders for all patients undergoing polysomnography.

**If available please fax a copy of this patient's most recent sleep disorders consultation and past sleep study reports to (831) 649-7211.**

\_\_\_\_\_  
Date / Time Physician Signature

Community Hospital of the Monterey Peninsula®

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