NORWICH Sleep Center

Medical Office Building - Backus Hospital
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Norwich, CT 06360
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REFERRAL FORM
(Request for Service)

PATIENT INFORMATION **DATE ORDERED:**

Last Name _____ First Name _____

Address _____ City _____ State _____ Zip Code _____

DOB _____ SSN _____ Daytime Phone (Work) _____

Evening Phone (Home) _____ Other Phone (Cell) _____

INSURANCE INFORMATION:

Primary Insurance _____ ID# _____ Group/Plan # _____

Subscriber _____ Employer _____ Authorization # _____

Secondary Insurance _____ ID# _____ Group/Plan # _____

Subscriber _____ Employer _____ Authorization # _____

SUSPECTED DISORDERS: (Check all that apply)

- ☐ Sleep Apnea
- ☐ Night Terrors
- ☐ Insomnia
- ☐ Nocturnal Seizures
- ☐ CHF
- ☐ Narcolepsy
- ☐ Sleep Walking
- ☐ EDS (Extensive Daytime Sleepiness)
- ☐ COPD
- ☐ Asthma
- ☐ RBD (REM Behavior Disorder)
- ☐ PLMS (Periodic Limb Movements of Sleep)
- ☐ RLS (Restless Leg Syndrome)
- ☐ Bruxism
- ☐ Cardiac Arrhythmia

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

- ☐ Initial Sleep Consultation ___ / ___ / ___
- ☐ Diagnostic Nocturnal Polysomnogram ___ / ___ / ___
- ☐ Split-Night Study ___ / ___ / ___
- ☐ CPAP Titration / BiPAP Titration ___ / ___ / ___
- ☐ Follow-up Appointment for Sleep Study ___ / ___ / ___
- ☐ MSLT (Multiple Sleep Latency Test) ___ / ___ / ___
- ☐ MWT (Maintenance of Wakefulness Test) ___ / ___ / ___
- ☐ CPAP Acclimation ___ / ___ / ___

RELEVENT MEDICAL HISTORY *** (Please forward most recent history and physical)**

Medications: _____

Primary Symptoms ☐ Witnessed Apneas ☐ Frequent Snoring ☐ Daytime Sleepiness ☐ Difficulty Falling Asleep ☐ Frequent Leg Movements During Sleep ☐ Obese/ Large Neck

Notes to Tech _____

Special Needs ☐ Nocturnal O2 @ ____ LPM ☐ Wheel Chair ☐ Caretaker/ Spouse ☐ Other: _____

THIS PATIENT IS BEING REFFERED BY:

Physician's Full Name (Please Print) _____ NPI#: _____

Address _____ City _____ State _____ Zip _____

Contact Person _____ Phone _____ Fax _____

Medical Director's Signature: _____ ***Date:*** _____

CONTACT ATTEMPTS: PACKET GIVEN Y / N

1ST _____

2ND _____

Please fax along with this form a copy of the patient's demographics, insurance card(s) and office notes.