Drs. Lacey & Freschi, P.C.

HOME SLEEP STUDY REFERRAL FORM

OFFICE TO COMPLETE		
Referring Doctor		
Practice Contact Name:	Practice Phone:	Practice Fax:

PATIENT INFORMATION			
Last Name:	Last Name:	M.I.:	Previous Name: (if applicable)
Mailing Address:			Apt #
City/State/Zip:			
Home Phone:	Cell Phone:		Work Phone:

PROVIDER TO COMPLETE

PRESENTING SYMPTOMS:

- ☐ Preliminary Diagnosis: Obstructive Sleep Apnea (G47.33)
- ☐ Loud Snoring
- ☐ Excessive daytime sleepiness
- ☐ Witnessed Apnea
- ☐ Insomnia
- ☐ Periodic Leg Movements (PLMs)
- ☐ Restlessness During Sleep
- ☐ Nocturnal Seizures
- ☐ Impaired Cognition
- ☐ Awakens with choking/gasping
- ☐ Sleep Bruxism
- ☐ Parasomnias

MEDICAL HISTORY:

- ☐ Hypertension
- ☐ Obesity BMI >30 kg/m2
- ☐ Sleep Apnea
- ☐ Diabetes
- ☐ Arrhythmias
- ☐ Neurologic disorder
- ☐ CHF
- ☐ Other - Please Specify:

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Allergies:

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Medications:

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Provider Printed Name: ____________________________________ Date: ____

Provider Signature: ____

Did you include the following information?

- ☐ Patient Demographics
- ☐ Copy of patient's insurance card
- ☐ Office/medical notes
- ☐ Previous Sleep Study Results
- ☐ If an insurance referral is required, please attach the approved referral to this order when faxing.

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