REFERRAL FORM

Appleton Clinic / Sleep and Fatigue Treatment Center
2499 Glades Rd., Ste. 110, Boca Raton, FL 33431
Phone (561) 450-8328 Fax (561) 450-5817

Patient's Name: _____ D.O.B: _____/_____/_____ S.S#_____-_____-_____

Home phone: (_____) - _____ - _____ Cell phone: (_____) - _____ - _____ ☐ Private Pay Patient

Primary Insurance Company: _____ Secondary Insurance: _____

☐ Sleep Consultation with Sleep Study — Includes consultation, sleep testing, ordering of equipment, and follow up visits as necessary
☐ Sleep Consultation — Sleep Medicine consultation and follow up visits as necessary at Sleep and Fatigue Treatment Center
☐ Psychiatry Consultation — Psychiatry consultation and follow up visits as necessary at Sleep and Fatigue Treatment Center

SYMPTOMS: (PLEASE CHECK ALL THAT APPLY) DURATION of complaints: Yrs _____ Months _____ Psych Symptoms:

☐ Sleep Apnea/Breathing Pauses during sleep	☐ Loud or Disruptive Snoring	☐ Attention Issues	☐ Depression
☐ Excessive Daytime Sleepiness (EDS)	☐ Somnolence or Drowsiness	☐ Behavioral Issues	☐ Anxiety
☐ Nocturnal Awakenings/ Arousals during sleep	☐ Fatigue or Malaise	☐ Narcolepsy	☐ Mania
☐ Chronic Insomnia	☐ Waking Up early in the A.M.	☐ Sleep Walking/Talking	☐ Panic Attacks
☐ Periodic Limb Movements during sleep	☐ Hot Flashes	☐ Co-Sleeping Issues	☐ PTSD
☐ Restless legs just prior to, or while falling asleep	☐ Frequent Nocturnal Urination	☐ Circadian Rhythm Disorder	☐ OCD
☐ Difficulty Falling Asleep	☐ Shift Work Disorder	☐ Cataplexy	☐ Psychosis
☐ Difficulty Staying Asleep	☐ Obesity	☐ Other:_____	

MEDICAL HISTORY: (PLEASE COMPLETE IN FULL)

Physical Exam: Vital signs: B.P. _____ / _____ HR: _____ Ht: _____ft. _____ in. Wt _____ lbs. Neck:____ inches.

Nose/Throat/Pharynx:	☐ normal	☐ abnormal	_____	☐↑ TONSILS ☐ SEPTAL DEV
Cardio-vascular:	☐ normal	☐ abnormal	_____	☐ HTN ☐ CHF ☐ CAD
Respiratory Function:	☐ normal	☐ abnormal	_____	☐ COPD ☐ ASTHMA ☐ PH
Abdomen:	☐ normal	☐ abnormal	_____	☐ GERD ☐ PUD
Neurological:	☐ normal	☐ abnormal	_____	☐ CVA ☐ PD ☐DEMENTIA
Other Significant Findings:	_____			☐ SEIZURES ☐ HEADACHES

Medications: _____Allergies: ☐ NKDA _____

REFERRING PHYSICIAN:

Name (Print):_____ NPI: _____ (P) (_____) - _____ - _____

Signature: _____ Date: _____ /_____ / _____ (F) (_____) - _____ - _____

IF YOU WISH TO ORDER A SLEEP STUDY:

☐ PSG (Overnight sleep study, split-night study as per protocol) ☐ MSLT (To evaluate narcolepsy & sleepiness; must follow PSG)
☐ CPAP/Bilevel Titration study (Therapeutic study after Dx of OSA) ☐ MWT (Daytime nap study to evaluate alertness, must follow PSG)

SLEEP STUDY ELIGIBILITY: (Check part A & part B to be eligible) ****IF PATIENT HAS MEDICARE YOU MUST CHECK BOXES 1, 2, 3 OR 4**

A
1 ☐ Snoring with choking/gasping or witnessed apnea episodes during sleep (R/O OSA)
2 ☐ Abnormal sleep behaviors with violent or injury episodes during sleep & EEG completed and normal (R/O PARASOMNIA)
3 ☐ Excessive daytime sleepiness with involuntary muscle weakness or night-time hallucinations (R/O NARCOLEPSY)
4 ☐ Periodic leg movements at night with excessive daytime sleepiness or fragmented sleep (R/O PLMD)
☐ Long-term excessive daytime sleepiness without symptoms of apnea (R/O IDIOPATHIC HYPERSOMNIA)

B ☐ The above condition is severe enough to interfere with the patient's well-being and health

OFFICE USE ONLY: **Board Certified Sleep Physician:** _____ ☐ **Reviewed** **Date:** _____ / _____ / _____

☐ Please check box if you need more referral forms. Please attach a copy of patient's insurance card and photo ID.