WakeMed Sleep Center
HealthPark at Kildaire
110 Kildaire Park Dr., Suite 405
Cary, NC 27518
Phone: 919-350-1879
FAX: 919-350-8959

WakeMed Sleep Center

Sleep Center Referral Form

Date: ________________________

PATIENT INFORMATION

Patient Name: ____ Date of Birth: ___________________ Gender: ☐ M ☐ F

Address: ____ City/State/Zip: ____

Phone *(Please circle preferred number)* Home: ____________________ Cell: __________________ Email: ________________________________

Primary Insurance: ____ ID#: __________________ MR#: ___________________

REFERRING PHYSICIAN INFORMATION

Name: ____

Address: ____ City/State/Zip: ____

Office Phone: ____________________________ Fax: ____________________________ NPI#: _____________________

PHYSICIAN ORDER

- ☐ Consult with Sleep Medicine Provider
- ☐ Home Sleep Test (HST)
- ☐ In-Lab Sleep Study (PSG):
  - ☐ Diagnostic Sleep Study
  - ☐ Split Night Sleep Study
  - ☐ CPAP Titration Sleep Study
- ☐ Multiple Sleep Latency Test (MSLT) with PSG

Check the symptoms that best describe the patient's sleep complaint.

- ☐ Apnea
- ☐ Excessive daytime sleepiness
- ☐ Disturbed or restless sleep
- ☐ Non-restorative sleep
- ☐ Frequent unexplained arousals from sleep
- ☐ Epworth Sleepiness Scale (ESS) greater than or equal to 10
- ☐ Fatigue
- ☐ Habitual snoring
- ☐ Choking or gasping during sleep
- ☐ BMI greater than or equal to 30
- ☐ Neck circumference great than 17 in (men) / 16 in (women)
- ☐ Bruxism
- ☐ Cognitive deficits
- ☐ Reflux
- ☐ Erectile dysfunction
- ☐ Apneas or hypoxemia during procedures with anesthesia
- ☐ Morning headaches

MEDICAL HISTORY

- ☐ Hypertension
- ☐ Congestive Heart Failure
- ☐ Atrial Fibrillation/SVT
- ☐ Neuromuscular Impairment
- ☐ Obesity
- ☐ Parkinson's Disease
- ☐ Acute Epilepsy
- ☐ History of Stroke
- ☐ Cognitive Impairment
- ☐ OSA (previously diagnosed)
- ☐ COPD
- ☐ Asthma
- ☐ Pulmonary Hypertension
- ☐ Oxygen Dependent
- ☐ Diabetes

Indication for Study:

- ☐ Periodic Limb Movement Disorder (G47.61)
- ☐ OSA (G47.33)
- ☐ Central Sleep Apnea (G47.31)

I certify that this service is medically necessary. The information provided is true, accurate and documented in the patient's clinical notes.

Physician Signature: ____

Fax this order, clinical notes and insurance information to 919-350-8959.