University | Sleep and Pulmonary Associates

Affiliated with UCSF School of Medicine Fresno Medical Education Program

6733 N. Willow Ave., Suite 107
Fresno, CA 93710
Phone: 559.435.4700
Fax: 559.298.7951

❑ Eyad Almasri, MD
❑ David W. Lee, MD
❑ Karl Van Gundy, MD
❑ Lynn Keenan, MD
❑ Rafael Zuzuarregui, MD

REFERRAL FOR SLEEP STUDY

Patient Information:

Name: _____ Home Phone: _____
Birth Date: _____ Work Phone: _____
Demographics: _____ Height _____ Weight: _____ Gender: M / F
Sleeping Hours: From _____ To _____ ❑ Night ❑ Day ❑ Evening
Occupation: _____

PRIMARY CARE PHYSICIAN

Requesting Physician: _____ Phone: _____ Fax: _____
PCP: _____ Phone: _____ Fax: _____

❑ **Consultation with Sleep Study to follow (No H&P required)**
– Included Progress Notes, insurance card and referral or authorization (if needed)
❑ **Direct Sleep Study (Please complete the following H&P and send copy of authorization)**

HISTORY AND PHYSICIAL INFORMATION

History of Sleep Problems

❑ Excessive Daytime Sleepiness ❑ Shift Work ❑ Morning Headaches
❑ Cataplexy ❑ Snoring ❑ Nocturia
❑ Witnessed Apneas ❑ Sleep Paralysis ❑ Frequent Awakenings
❑ Claustrophobia ❑ Insomnia ❑ Sleepwalking
❑ Other _____

Medical Conditions

None❑ _____ ❑ Cardiac Arrhythmias ❑ HTN
_____ ❑ CHF ❑ Diabetes
_____ ❑ Neuromuscular Disorders ❑ Asthma/COPD
_____ ❑ Stroke/Weakness ❑ Chronic Pain
_____ ❑ Seizures ❑ Fibromyalgia

Social History & Family History

NA ❑ _____ _____
_____ _____

Physical Exam

NL ❑ _____ HEET
NL ❑ _____ Heart/Lungs:
NL ❑ _____ Neurologic Exam:

STUDY TYPES/CPT CODES

Type ❑ Standard 95810 ❑ MSLT 95805
❑ CPAP/BPAP Titration 95811 ❑ Home Sleep Study
❑ Split-night (if indicated) 95810-95811 ❑ Pediatric Polysomnography
❑ At the discretion of the Sleep Center ❑ Other _____
❑ Hypoventilation evaluation (please include room air ABG)

DIAGNOSIS AND SPECIAL NEEDS

Diagnosis

❑ Obstructive Sleep Apnea ❑ Narcolepsy ❑ Seizures
❑ PLMD/Restless Legs/RBD ❑ Hypersomnia ❑ Neuromuscular
❑ Sleepwalking ❑ Shift Work ❑ Insomnia

Special Needs

_____ ❑ Oxygen ❑ Assistance Moving ❑ Wheelchair
_____ ❑ Difficulty ❑ Other

Ordering Physicians Signature: _____ *Date:* _____

❑ My office will do the follow up after the study.
❑ Please arrange for a sleep follow up post study in the Sleep Center.

Appointment Date & Time: _____