SLEEP DIAGNOSTICS OF NEW YORK, INC.

69-39 Yellowstone Blvd, Suite #1 **35-50 82nd Street, Suite# 1A**
Forest Hills, NY 11375 **Jackson Heights, NY 11372**
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Email: SleepDiagnostics@msn.com

Physician Referral Form for Sleep Study

***Please complete and include a copy of the insurance card**

Date: _____

Patient's Name _____
(Print) Last First MI
Home Phone: _____ Work Phone_____
Home Address: _____
City: _____ State: _____ Zip: _____
Sex: _____Male___ Female DOB: _____S.S#_____
Marital Status: ___M___S___D__W Age: _____Height:_____ Weight:_____

Insurance Information:
Name of Insurance: _____
Policy ID #:_____
Name of Insurance policy holder: _____
Phone Number: _____

Primary Physician:
_____Phone:_____
Fax: _____
Address: _____

Referring Physician:
_____Phone:_____
Fax: _____
Address: _____

Sleep Habits and Patterns:
1. Snore___Yes____No # of years_____
2. Witnessed Apnea by: _____

Epworth Scale: (Chance of dozing on a scale of 0-3
0=Never 1=Slight 2=Moderate 3=High
1. Sitting and reading: _____
2. Watching television: _____
3. Sitting inactive in public area: _____
4. Lying down in the afternoon: _____
5. Sitting talking with someone: _____

PSG Protocol: ___PSG____CPAP(as clinically indicated)____ PSG Insomnia ____PSG MSLT _____Night Time Oxygen (*Request must be followed with a prescription with liter flow duration)*

Dental Protocol:____ Dental Evaluation/Oral Appliance (as clinically indicated)

Clinical Notes: _____
_____

Physician Signature: _____Date:_____