The Brooklyn Hospital Center
Keeping Brooklyn healthy.

Sleep Disorder Center
121 DeKalb Avenue, Brooklyn, NY 11201
Tel: 800.540.4485

SLEEP STUDY REFERRAL FORM – PLEASE FAX TO 914-631-7852

Patient: _____ **Sex:** _____ **DOB:** _____ **SSN:** _____
Address: _____ **City/State/Zip:** _____
Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____
Insurance: _____ **ID#:** _____ **Group#:** _____
Insured Name: _____ **Insured DOB:** _____ **Insured SSN:** _____

TYPE OF STUDY REQUESTED:

☐ I would like my patient seen in consultation with the Sleep Specialist: ☐Before testing ☐After testing
☐ **Comprehensive PSG, CPAP (if AHI>5 on NPSG) & BiPAP Placement for home use**
☐ Nocturnal polysomnogram (NPSG) 95810
☐ Split night study (NPSG/CPAP)
☐ CPAP titration study 95811
☐ Non-invasive ventilation titration study for hypoventilation 95811
☐ NPSG with Multiple Sleep Latency Test (MSLT) 95805
☐ Maintenance of Wakefulness Test (MWT) 95805
☐ Administer supplemental O_2 at _____L/min
☐ Pt. has Trach, do study (circle: **Opened** or **Closed)**

Special Instructions/Needs: _____

MEDICAL DOCUMENT: **Please attach medical record that necessitated the sleep referral**
MEDICAREPATIENTS: **History/Physical notes of office visit must accompany this referral. Also please complete the vitals listed.**

Height: _____ **Weight:** _____ **BMI:** _____ **Neck Circumference:** _____

Suspected Sleep Condition Resulting in Referral (MUST CHECK AT LEAST ONE):

☐ Sleep Apnea (G47.33)
☐ Restless Sleep (G47.8)
☐ Periodic Limb movements (G47.61)
☐ REM Behavior Disorder (G47.52)
☐ Sleepiness (G47.10)
☐ Sleep Walking (F51.3)
☐ Night Terrors (F51.3)
☐ Narcolepsy (G47.419)
☐ Hypoventilation (G47.36)

Indication for Polysomnography/ Symptoms (must check at least TWO):

☐ Snoring
☐ Excessive Daytime sleepiness
☐ Witnesses pauses in breathing while asleep
☐ Awaken with gasping or choking sensation
☐ Difficulty falling asleep or staying asleep
☐ Sleep paralysis
☐ Waking with a headache
☐ Waking feeling tired
☐ Restless sensation in arms or legs
☐ Kicking movements while asleep
☐ Impaired daytime concentration/memory or mood change
☐ Sudden loss of muscle strength brought on by strong emotion
☐ Other: _____

Medical History

☐ Hypertension
☐ Pulmonary Hypertension
☐ Diabetes
☐ Cardiac Problems
☐ Mood Disorder
☐ Congestive Heart Failure
☐ Asthma
☐ Nasal Obstruction
☐ Nocturnal Reflux/GERD
☐ Other Psychiatric illness (specify) _____
☐ Seizures
☐ Emphysema
☐ Obesity
☐ Stroke
☐ Currently on CPAP/Bi-Level _____cm H2O ☐ Previous Sleep Study (location & date): _____
☐ **ALLERGIES (Please Note):** _____

I AUTHORIZE BROOKLYN HOSPITAL SLEEP CENTER TO PERFORM SLEEP STUDY ON ABOVE PATIENT ACCORDING TO THEIR PROTOCOLS, INCLUDING URGENT INITIATION OF OXYGEN & CPAP.

Physician Name: _____ **Signature:** _____
Date: _____ **NPI:** _____ **License#:** _____
Address: _____ **City/State/Zip:** _____
Phone: _____ **Fax:** _____ **email:** _____ **Specialty:** _____

After completing, Please fax to 914-631-7852

Rev 8'21