Illinois Neurological Institute Sleep Center Physician's Referral Form

Adults (>/=18 yrs)

Section 1

Patient's Name_____ Date of Birth_____
Patient's Address_____
Home ph#_____ Work ph#_____
Does this patient currently use CPAP or BiPAP? ___ Mobile/other ph#_____
Email address: _____
Who is this patient's insurance carrier? _____
(If patient has Humana Insurance, no appointments will be scheduled until we receive their referral)

***Reason for referral** (please be specific):_____

!! If you want an office consultation before testing need is determined, go to Section 3 (skip Section 2).

Section 2 (for patients referred for testing before or without office consultation)

Choose sleep specialist to read study (if indicated) and see patient (unless ordering testing only):

_____**INI Sleep Center Physician (Sarah Zallek, M.D. or Bradley Gleason, M.D.)**
_____ Please schedule appointment _____ Patient will call to schedule appointment

_____**Illinois Lung Institute (ILI)**
_____ Referring Physician will contact ILI for appointment _____ OSF to notify ILI for appointment

Check here if testing only_____ (The patient will be seen by a sleep specialist unless the referring physician requests testing only. Treatment for sleep apnea (such as CPAP) will not be ordered unless the patient will be seeing the sleep specialist. A referral to the sleep specialist may also be made at any time after testing.)

Please check each that applies:

_____ Snoring
_____ Stopping breathing in sleep (witnessed apnea)
_____ Excessive sleepiness
_____ Fatigue
_____ Difficulty falling asleep or staying asleep
_____ Dreams just before sleep or after waking (hypnogogic hallucinations)
_____ Sudden weakness when laughing or angry (cataplexy)
_____ Kicking in sleep
_____ Restlessness in legs that keeps him/her awake
_____ Inability to move just before sleep or after waking (sleep paralysis)
_____ Unusual or unwanted behavior in sleep (*briefly describe*_____ _____)

	Circle any that apply
Do you suspect this patient may have sleep apnea?	Yes No
Do you suspect this patient may have narcolepsy?	Yes No
Do you suspect this patient may have restless legs syndrome?	Yes No
Do you suspect this patient may have periodic leg movements in sleep?	Yes No
Is insomnia a significant problem for this patient?	Yes No

Medical History: (circle all that apply) HTN CAD CHF COPD Asthma Depression Diabetes
Please note any other significant medical history: _____

Physical Exam: Height_____ Weight_____ Neck circumference _____
large uvula Y / N crowded oropharynx Y / N retrognathia or micrognathia Y / N

Please note any abnormalities of the following: tongue, nasal passages, dentition, maxilla or mandible_____

_____

Is this patient on supplemental **oxygen** therapy? Yes No If yes, how much?_____

When is used? _____daytime only _____ nighttime only _____ 24 hrs _____ PRN

If sleep apnea is found during a polysomnogram, may we initiate **CPAP** treatment in a split night study? Yes No

Does the patient have any disability that would require extra assistance during a sleep study? Yes No

Section 3

Office Location and Fax Number for this Patient's Correspondence:_____

Ordering Physician's Signature_____

Print resident's name_____ **Print attending's name** _____

Ordering Physician's phone # _____ **Today's Date**_____
fax to 655-6967

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