QUEEN'S SLEEP CENTER

The Queen's Medical Center
1301 Punchbowl St. Honolulu, HI 96813
Tel: (808) 691-4396 Fax: (808) 691-7830

The Queen's Medical Center West Oahu
91-2141 Fort Weaver Rd.
Tel: (808) 691-3799 Fax: (808) 691-3760

AMERICAN ACADEMY OF SLEEP MEDICINE
WAKE SLEEP
ACCREDITED MEMBER CENTER

PROVIDER REFERRAL REQUEST FORM
Requisition for a Sleep Study

Patient Name: _____ Date of Birth: _____/_____/_____ Age: _____

Ht: _____In Wt: _____lbs Phone Number: (1) _____ (2) _____

Insurance: (1) _____ (2) _____ Circle one: M F

Medication(s): _____

Allergies: _____

Please Circle All Appropriate Items

Pulmonary Disease: Asthma Bronchitis COPD CO2 Retention Hypoxemia Other: _____

Oxygen Use: No Yes _____lpm CPAP/ BIPAP/ ASV Use: No Yes _____cmH2O

Is this a follow-up study: No Yes Reason for follow-up study: Weight Loss Weight Gain New Machine

Symptoms on CPAP Requested by Insurance Other: _____

SLEEP HISTORY
Check All Appropriate Items

MAJOR CRITERIA – AT LEAST ONE (1) REQUIRED

_____ Documented Unexplained Sleep-Related Cardiac Arrhythmias
_____ Documented Unexplained Sleep-Related Oxygen Desaturation
_____ Observed Apnea
_____ Snoring
_____ Documented Sleep Apnea
_____ Excessive Daytime Somnolence

MINOR CRITERIA - TWO (2) OR MORE REQUIRED IF ONLY ONE (1) MAJOR CRITERIA INDICATED

_____ Neuromuscular Disease
_____ Cerebrovascular Accident
_____ Cor Pulmonale (Unexplained)
_____ Decreased Cognitive Function
_____ Memory Impairment
_____ Morning Headaches
_____ Hypertension
_____ Obesity
_____ Polycythemia
_____ Hypothyroidism (Untreated)

HEENT ABNORMALITIES

_____ Craniofacial Abnormality (Down's syndrome, Acromegaly)
_____ Enlarged Tonsils/ Adenoids
_____ Long Soft Palate
_____ Macroglossia
_____ Micrognathia
_____ Nasal Obstruction

OTHER

_____ Narcolepsy _____ Sleep-Related Myoclonus _____ Other: _____

The above criteria is sufficient for a Sleep Test Order but DOCUMENTATION of the above criteria is required in the CONSULTATION notes for insurance purposes.

Referring Physician's Signature: _____ Date: _____

Referring Physician Name: _____ Phone: _____ Fax: _____

FOR OFFICE USE ONLY
Date Received: _____ **Received by:** _____ **MRN:** _____