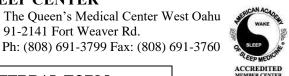
## THE QUEEN'S SLEEP CENTER



The Queen's Medical Center 1301 Punchbowl St. Honolulu, Hawaii 96813 91-2141 Fort Weaver Rd. Ph: (808) 691-4396 Fax: (808) 691-7830

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## SLEEP CENTER REFERRAL FORM

Patient Name:		Hospital MRN	:		
Sex: M F Age:	Date of Birth:		Ht:	In. Wt:	lbs.
Insurance:	Patient Contact Number:				
		<u>TESTING</u>			
☐ <b>Sleep Testing Only:</b> Referring	ng physician will manage tr	reatment and follow-u	p		
(Medical Director will determine		ull-night polysomnograp Test (HST), MSLT, MW		somnography, CPAP E	valuation,
	Please Chec	k All Appropriate It	<u>ems</u>		
Pulmonary Disease:	ma Bronchitis CO	PD CO2 Retention	n Hypoxemia	Other:	
	SLJ	EEP HISTORY			
		All Appropriate Items			
	Major Criteria	- At least one (1) re	equired		
Documented Unexplain	ed Sleep-Related Cardia	c Arrhythmias	Snoring		
	ed Sleep-Related Oxyger	n Desaturation	<del></del>	d Sleep Apnea	
Observed Apnea			Excessive D	aytime Somnolen	ce
		Min on Chitomia			
	(TWO or more real	Minor Criteria uired, if only 1 majo	r criterion indic	ested)	
☐ Neuromuscular Diseas		uncu, nomy i majo	Morning H		
Cerebrovascular Accide			☐ Hypertensi		
Cor Pulmonale (unexpl	lained)		Obesity		
Decreased Cognitive F		Polycythem	nia		
Memory Impairment			Hypothyroi	idism (untreated)	
☐ Pulmonary Hypertensi			H		
		HEENT Abnormalit			
	lity (Down's Syndrome, A	cromegaly)	☐ Macrogloss		
Enlarged Tonsils / Ade	noids		☐ Micrognath		
Long Soft Palate			☐ Nasal Obst	cruction	
☐ Narrow High-Arched F	'alate	0.1			
		Other:			
☐ Narcolepsy	☐Sleep-Related My	ocionus 🗆 Otne	er:		
The above criteria is sufficie	ent for a SLEEP TEST ORI	DER but DOCUMENT	ATION of the abo	ove criteria is REQU	IRED in
	PROGRESS NOT	ES for INUSRANCE	purposes.	•	
** PLEASE INCLUDE PA	TIENT'S DEMOGRAPHIC	C INFO, INSURANĈ	CE, & PROGRES	S NOTES. THANK	YOU. **
Referring Physician's Signatu	ıre:		D	ate:	
Dafamin - Dharaid		DI		T7:	
Referring Physician: (Please Print Name)		rnone·		_Fax:	
(I lease I fillt Ivaille)					