



**THE QUEEN'S SLEEP CENTER**

The Queen's Medical Center  
1301 Punchbowl St. Honolulu, Hawaii 96813  
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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: \_\_\_\_\_

**CONSULTS and TEST: CHOOSE ONLY (1) ONE**

- Sleep Consultation and Management:** Sleep Specialist to manage, testing, treatment, and follow-up
- Sleep Testing Only:** Referring physician will manage treatment and follow-up  
*(Medical Director will determine appropriate test: Diagnostic full-night polysomnography, Split-night polysomnography, CPAP Evaluation, Home Sleep Test (HST), MSLT, MWT)*

**Please Check All Appropriate Items**

**Pulmonary Disease:** Asthma Bronchitis COPD CO2 Retention Hypoxemia Other: \_\_\_\_\_

Was a previous sleep study done within the last 5 years? \_\_\_\_\_ If yes, send us a copy of previous sleep study

**SLEEP HISTORY**  
Check All Appropriate Items  
**Major Criteria - At least one (1) required**

<input type="checkbox"/> Documented Unexplained Sleep-Related Cardiac Arrhythmias <input type="checkbox"/> Documented Unexplained Sleep-Related Oxygen Desaturation <input type="checkbox"/> Observed Apnea <input type="checkbox"/> Cataplexy	<input type="checkbox"/> Snoring <input type="checkbox"/> Documented Sleep Apnea <input type="checkbox"/> Excessive Daytime Somnolence <input type="checkbox"/> Idiopathic Hypersomnia
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**Minor Criteria**  
(TWO or more required, if only 1 major criterion indicated)

<input type="checkbox"/> Neuromuscular Disease <input type="checkbox"/> Cerebrovascular Accident <input type="checkbox"/> Cor Pulmonale (unexplained) <input type="checkbox"/> Decreased Cognitive Function <input type="checkbox"/> Memory Impairment <input type="checkbox"/> Pulmonary Hypertension	<input type="checkbox"/> Morning Headaches <input type="checkbox"/> Hypertension <input type="checkbox"/> Obesity <input type="checkbox"/> Polycythemia <input type="checkbox"/> Hypothyroidism (untreated)
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**HEENT Abnormalities**

<input type="checkbox"/> Craniofacial Abnormality (Down's Syndrome, Acromegaly) <input type="checkbox"/> Enlarged Tonsils / Adenoids <input type="checkbox"/> Long Soft Palate <input type="checkbox"/> Narrow High-Arched Palate	<input type="checkbox"/> Macroglossia <input type="checkbox"/> Micrognathia <input type="checkbox"/> Nasal Obstruction
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**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 PROGRESS NOTES for INSURANCE purposes.

**\*\* PLEASE INCLUDE PATIENT'S DEMOGRAPHIC INFO, INSURANCE, & PROGRESS NOTES. THANK YOU. \*\***

Referring Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
(Please Print Name)