National Jewish Health
Science Transforming Life®

SLEEP CENTER REFERRAL FORM

Phone 303-270-2708 Fax 303-270-2109

NPI: 1326015777

Main Campus	*Broomfield Campus*	*DTC Campus*
1400 Jackson St	480 Flatiron Blvd	7877 S. Chester St.
Denver, CO 80206	Broomfield, CO 80021	Englewood, CO 80112

PATIENT INFORMATION

Last Name _____ First Name _____ MI _____ Gender: ☐ M ☐ F

DOB _____ SS# _____ Marital Status ☐ S ☐ M ☐ D ☐ W

Street Address: _____ Apt/PO _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Cell _____

PRIMARY INSURANCE _____ ID# _____ Group _____

Address _____ Phone _____

Subscriber _____ Guarantor _____ DOB _____

Employer _____

THIS PATIENT IS BEING REFERRED FOR: (Please check all that apply)

☐ Sleep Consultation with Sleep Study — Sleep Specialist Consultation for evaluation, diagnostic testing and treatment.

☐ Clinic Consultation

☐ Sleep Study (Baseline Only, Baseline with PAP, PAP Titration, or HST (Home Sleep Testing)

☐ Multiple Sleep Latency Test following Overnight Sleep Study

☐ Maintenance of Wakefulness Test

All testing will adhere to American Academy of Sleep Medicine Practice Parameters. For medical documentation and to satisfy insurance guidelines for reimbursement, adequate baseline data and sleep time will be collected before attempting treatment intervention. Split-night studies will be performed whenever appropriate.

SUSPECTED DISORDERS and Relevant Medical History: (Check all that apply)

☐ Obstructive Sleep Apnea
☐ Obesity with BMI > 45
☐ BMI< 30
☐ OSA treatment failure
☐ Narcolepsy
☐ Insomnia
☐ Central or Complex Sleep Apnea
☐ Moderate to severe pulmonary disease (pO2 <60 or pCO2>45)
☐ Neuromuscular disease (e.g. Parkinson's, spina bifida, myotonic dystrophy)
☐ Other critical health information _____

☐ Periodic Limb Movements (PLMs)
☐ Parasomnias/Nocturnal Seizures
☐ Upper Airway Surgery
☐ Stroke
☐ Epilepsy
☐ CHF
☐ Prior Sleep Study:
  ☐ in lab PSG Date: _____
  ☐ HST Date: _____

Primary Care Physician: _____ Phone _____ Fax _____

Referring Physician:
Print Name: _____ Phone _____ Fax _____
Address — Reports will be sent here

Signature: _____ Date: _____ NPI #: _____

Complete Epworth scale on back side of page. Fax both sides of sheet to 303-270-2109.

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Epworth Sleepiness Scale

Last Name _____ First Name _____ DOB: _____

How likely are you to doze off or fall asleep in the following situations? This refers to the usual way of life in recent times

If you have not done some of these things recently, estimate how you might have reacted.

0- would never doze
1- slight chance of dozing
2- moderate chance of dozing
3- high chance of dozing

	Chance of Dozing Score
___	Sitting and reading
___	Watching TV
___	Sitting, inactive in a public place (e.g. a theatre or a meeting)
___	As a passenger in a car for an hour without a break
___	Lying down to rest in the afternoon when circumstances permit
___	Sitting and talking to someone
___	Sitting quietly after a lunch without alcohol
___	In a car while stopped for a few minutes in traffic

Total ___

Reference: Johns MW. A new method for measuring daytime sleepiness: the Epworth sleepiness scale. Sleep. 1991 Dec;14(6):540-5.

Complete Epworth scale above. Fax both sides of sheet to 303-270-2109.