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HAWAI'I PACIFIC HEALTH | STRAUB MEDICAL CENTER
CREATING A HEALTHIER HAWAI'I

SLEEP CENTER REFERRAL REQUEST

TODAY'S DATE:_____

PATIENT NAME:_____

PHONE:_____

ADDRESS:_____

CITY: _____ STATE:_____

ZIP:_____ SEX: _____ DOB: _____

NECK CIRCUMFERENCE (in):_____ BMI: _____

Primary Insurance:_____

Policy #:_____

Secondary Insurance: _____

Policy #:_____

Prior-Auth: _____ Requested _____ Not required

Diagnosis Code(s): _____

_____

CONSULT and TESTS

❑ Sleep Consultation for diagnostic testing, treatment and follow up

❑ Diagnostic In-Lab Polysomnogram (PSG)

❑ Split-Night In-Lab PSG *CPAP started if indicated*

❑ Positive Airway Pressure (PAP) Titration Study

❑ Multiple Sleep Latency Test (MSLT)

❑ Home Sleep Apnea Test (HSAT)

SPECIAL NEEDS

❑ Primary Language Spoken _____

❑ Fall Risk ❑ Mentally Impaired ❑ Other _____

URGENCY

❑ Not Urgent ❑ Urgent due to: ____ Driving Risk

____ Severe hypoxemia O2<80% ____ Job Sensitive

PRIOR SLEEP STUDY *Please send report if available*

❑ PSG ❑ HSAT Study Date: _____

SIGNS/SYMPTOMS and MEDICAL CONDITIONS

Please check all that apply

❑ Observed apneas ❑ Snoring

❑ Known OSA ❑ CPAP Use _____ cm of H2O

❑ Unrefreshed sleep/somnolence ❑ Sleep related gasping/choking

❑ BMI>30 ❑ Inability to lie flat

❑ Tonsillar Hypertrophy ❑ Mallampati 3 or 4

❑ Sleep-related movement disorder ❑ Parasomnias

❑ Central Sleep Apnea ❑ Narcolepsy

❑ Chronic Insomnia ❑ Restless Leg Syndrome

❑ HTN ❑ Coronary Artery Disease

❑ Hypothyroidism ❑ Polycythemia

❑ CHF NYHA _____ EF% _____

❑ COPD ❑ Asthma _____Moderate _____Severe

❑ Pulmonary HTN ❑ Continuous/Nocturnal O2 use at ___L

❑ Epilepsy ❑ Opiate dependence

❑ Stroke Onset >30 days ❑ Neuromuscular Disorder

❑ Intellectual disability or severe mental illness

REFERRING PROVIDER:_____

PHONE:_____

FAX:_____

Please fax completed form to (808) 522-3048

Attach H&P and any other supporting documentation

SIGNATURE: _____ DATE: _____ TIME: _____

Submit Form