Norwood Hospital
A STEWARD FAMILY HOSPITAL
Steward

REQUEST FOR SLEEP STUDY

THE SLEEP CENTER
Balsamo Building
52 Guild Street
Norwood, MA 02062
Phone (781) 278-6111
Fax (781) 278-6112

Referral Date: _____ Patient Name: _____ DOB:_____

Address: _____ Town: _____ State: _____ Zip: _____

Gender: M / F Home Phone: _____ Cell Phone: _____ Work: _____

Insurance: _____ Policy #: _____ Secondary Ins:_____

REQUESTED SERVICE: (Please select only one study below)

□ **HOME SLEEP TEST:** Screening test for sleep apnea

□ **COMPLETE CARE:**
(Consultation & Management) Office evaluation and diagnostic testing, including the treatment and home PAP coordination if clinically indicated.

BMI: _____

Height: _____

Weight: _____

ORDER DIAGNOSIS:

□ Sleep Apnea, unspecified (ICD-10 G47.30)

□ Obstructive Sleep Apnea (ICD-10 G47.33)

□ Other: _____ ICD-10: _____

PLEASE SELECT ALL SLEEP PROBLEMS & MEDICAL CONDITIONS THAT APPLY:

□ Witnessed apneas	□ Snoring	□ Gasping/choking	□ Obesity (BMI>30)/large neck
□ Depression	□ Morning headaches	□ Excessive daytime sleepiness	□ Fatigue
□ Difficulty falling asleep	□ Hypertension	□ Pulmonary disease	□ Insomnia
□ Unrefreshed sleep	□ Hx of stroke or MI	□ Congestive Heart Failure	□ Type 2 diabetes
□ Coronary artery disease	□ Other: (specify) _____		

REQUIRED ADDITIONAL PAPERWORK:

- **Recent office visit note**
- **Epworth sleepiness scale**

Referring Physician: _____ **NPI:** _____

Address: _____ **Phone:** _____ **Fax:** _____

Town: _____ **State:** _____ **Zip:** _____

PCP: _____ **Phone:** _____ **Fax:** _____

Referring Physician Signature: _____ **Date:**_____