Carney Hospital

A STEWARD FAMILY HOSPITAL

2100 Dorchester Avenue, Third floor
Dorchester, MA 02124
www.steward.org/Carney-Hospital

Referral Phone: (617) 506-4369
Referral Fax: (617) 506-4368

PATIENT INFORMATION

Name		Home Phone		DOB	
Street Address		Work/Cell Phone		M/F	
City, State, Zip		Email Address			
Insurance		Insurance ID #			
Subscriber		Medical Record #			

PATIENT IS BEING REFERRED FOR (check only ONE from this section)

Sleep Study, Evaluation and Treatment

- ○ **Consultation and Management**
  - → Visit with a sleep specialist to evaluate and treat patient.
    Heidi O'Connor, M. D.
    Alexander White, M. D.
- ○ **Sleep Study and Treatment**
  - → Includes sleep study (split night sleep study – first part diagnostic, second part CPAP titration if criteria met), post study consult and PAP therapy initiation (if indicated).
- ○ **Home Sleep Study and Treatment (adult only)**
  - → Includes sleep study, post study consult and PAP therapy initiation (if indicated). Patient has high probability of moderate-to-severe OSA and no significant co-morbid medical conditions or sleep disorders (appropriate insurance coverage required).
- ○ **Oral Appliance Evaluation and Treatment**
  - → Evaluation and fabrication (as appropriate) of oral appliance to treat snoring or sleep apnea.

Sleep Study Only (Results sent to referring physician for further management.)

- ○ **Diagnostic Sleep Study**
  - → Full night polysomnography (PSG).
- ○ **Split Night Sleep Study**
  - → Full night sleep study. First part diagnostic, second part CPAP titration if criteria met.
- ○ **CPAP or Bi-level PAP Titration (circle one)**
  - → Full night titration for patients with documented sleep apnea.
- ○ **Diagnostic Sleep Study and Multiple Sleep Latency Test (MSLT)**
  - → Daytime nap test following a full night diagnostic PSG study to diagnose narcolepsy or excessive sleepiness.
- ○ **Home Sleep Study (adult only)**
  - → Patient has high probability of moderate-to-severe OSA and no significant co-morbid medical conditions or sleep disorders (appropriate insurance coverage required).

MEDICAL HISTORY (a recent history and physical examination is required)

Suspected Disorder(s)

- ☐ Obstructive sleep apnea (OSA)
- ☐ Narcolepsy
- ☐ Nocturnal seizures/parasomnias
- ☐ Insomnia
- ☐ Restless legs syndrome (RLS) or periodic limb movements of sleep (PLMS)

Primary Symptoms

- ☐ Snoring/gasping/choking
- ☐ Witnessed apneas
- ☐ Obese/large neck
- ☐ Daytime sleepiness
- ☐ Difficulty falling asleep
- ☐ Fragmented sleep
- ☐ Frequent leg movements during sleep

Special Needs

- ☐ Nocturnal O2 (level: _____)
- ☐ Interpreter (language: _____)
- ☐ Wheelchair
- ☐ Currently using PAP (pressure: _____cm)
- ☐ Other _____

Medications and/or comments: _____

PHYSICIAN INFORMATION

Referring Physician		**Primary Care Physician** Same as Referring Physician ☐ Yes ☐ No	
Name		Name	
Street Address		Street Address	
City, State, Zip		City, State, Zip	
Phone		Phone	
Fax		Fax	
Email Address		Email Address	

Physician's Signature _____ **Date** _____