

Illinois Neurological Institute Sleep Center Physician's Referral Form

Adults (>=18 yrs)

Section 1

Patient's Name _____ Date of Birth _____

Patient's Address _____

Home ph# _____ Work ph# _____

Does this patient currently use CPAP or BiPAP? Mobile/other ph# _____

Who is this patient's insurance carrier? _____

(If patient has OSF Healthplans, no appointments will be scheduled until we receive their referral)

*Reason for referral (please be specific): _____

!! If you want an office consultation before testing need is determined, go to Section 3 (skip Section 2).

Section 2 (for patients referred for testing before or without office consultation)

Choose sleep specialist to read study (if indicated) and see patient (unless ordering testing only):

_____ INI Sleep Center Physician (Sarah Zallek, M.D. or Bradley Gleason, M.D.)

_____ Please schedule appointment _____ Patient will call to schedule appointment

_____ Illinois Lung Institute (ILI)

_____ Referring Physician will contact ILI for appointment _____ OSF to notify ILI for appointment

Check here if testing only _____ (The patient will be seen by a sleep specialist unless the referring physician requests testing only.)

Treatment for sleep apnea (such as CPAP) will not be ordered unless the patient will be seeing the sleep specialist. A referral to the sleep specialist may also be made at any time after testing.)

Please check each that applies:

_____ Snoring	_____ Sudden weakness when laughing or angry (cataplexy)
_____ Stopping breathing in sleep (witnessed apnea)	_____ Kicking in sleep
_____ Excessive sleepiness	_____ Restlessness in legs that keeps him/her awake
_____ Fatigue	_____ Inability to move just before sleep or after waking (sleep paralysis)
_____ Difficulty falling asleep or staying asleep	_____ Unusual or unwanted behavior in sleep (<i>briefly describe</i> _____)
_____ Dreams just before sleep or after waking (hypnagogic hallucinations)	

Circle any that apply

Do you suspect this patient may have sleep apnea? Yes No

Do you suspect this patient may have narcolepsy? Yes No

Do you suspect this patient may have restless legs syndrome? Yes No

Do you suspect this patient may have periodic leg movements in sleep? Yes No

Is insomnia a significant problem for this patient? Yes No

Medical History: (circle all that apply) HTN CAD CHF COPD Asthma Depression Diabetes

Please note any other significant medical history: _____

Physical Exam: Height _____ Weight _____ Neck circumference _____

large uvula Y / N crowded oropharynx Y / N retrognathia or micrognathia Y / N

Please note any abnormalities of the following: tongue, nasal passages, dentition, maxilla or mandible _____

Is this patient on supplemental oxygen therapy? Yes No If yes, how much? _____

When is used? _____ daytime only _____ nighttime only _____ 24 hrs _____ PRN

If sleep apnea is found during a polysomnogram, may we initiate CPAP treatment in a split night study? Yes No

Does the patient have any disability that would require extra assistance during a sleep study? Yes No

Section 3

Office Location and Fax Number for this Patient's Correspondence: _____

Ordering Physician's Signature _____

Print resident's name _____

Print attending's name _____

Ordering Physician's phone # _____

Today's Date _____

fax to 655-6967

Revised 4.3.08