Mass General Brigham
Salem Hospital

NORTH SHORE Physicians Group

Sleep Study / Sleep Consultation Referral Form PHONE: 978-354-4397 FAX to: 978-740-4901

Name: ______________________ DOB: ____________ Best Phone: ______________
Address: ______________________ Insurance: ______________________________
Physician Phone: ________________ FAX: ____________ PCP Name: ______________

1. Choose the appropriate Clinical Disorder Pathway:

☐ **Expedited evaluation for suspected sleep apnea.** When provided with complete information, we will:

- Obtain insurance prior authorization for sleep study (when required) and
- Schedule and perform in-laboratory polysomnography or home sleep testing (HST)
- Schedule consultation with sleep specialist to review results and determine appropriate treatment.

☐ **All other suspected sleep disorders:** patient will be scheduled for sleep specialist consultation prior to testing.

2. Required information for insurance prior authorization (PA cannot be obtained without this information):

Check all that apply:

☐ Excessive Daytime Sleepiness (EDS)
☐ Disturbed sleep
☐ Restless sleep
☐ Non-restorative sleep
☐ Witnessed apneas
☐ Gasping/choking in sleep
☐ Snoring
☐ Retrognathia
☐ Tonsillar hypertrophy
☐ Upper airway soft tissue abnormality
☐ Refractory hypertension
☐ Morning headaches
☐ Decreased concentration
☐ Irritability
☐ Nocturia
☐ Decreased libido
☐ Pre-op bariatric surgery

Comorbid conditions or potential contraindications to HST?

☐ Stroke in last 30 days
☐ TIA
☐ CAD
☐ Sustained SVT
☐ Sustained bradycardia
☐ 18 years or younger
☐ Moderate or severe COPD (FEV1 <80%)
☐ CHF class III/IV
☐ CHF with h/o ventricular fibrillation or ventricular tachycardia w/o ICD
☐ Cognitive impairment (inability to perform HST alone)
☐ Oxygen dependent
☐ Current use of opiates
☐ BMI >33 and serum bicarbonate >28
☐ Obesity hypoventilation syndrome (BMI >30 and arterial PCO2 >45mmHg)

Other: ____

3. Height: _____ Weight: _____ BMI: _____ Neck size: _____inches Duration of symptoms: ____months

4. EPWORTH SLEEPINESS SCALE (ESS):

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.	**0 = would never doze** **1 = slight chance of dozing** **2 = moderate chance of dozing** **3 = high chance of dozing**
— Sitting and reading	0 1 2 3
— Watching TV	0 1 2 3
— Sitting, inactive in a public place	0 1 2 3
— As a passenger in a car for an hour without a break	0 1 2 3
— Lying down to rest in the afternoon when circumstances permit	0 1 2 3
— Sitting and talking to someone	0 1 2 3
— Sitting quietly after lunch without alcohol	0 1 2 3
— In a car, while stopped for a few minutes in traffic	0 1 2 3
Total	

5. Previous sleep study ☐ Yes ☐ No If yes, when? ______________

Special needs:
☐ Assistance in/out of bed ☐ Incontinence ☐ Needs interpreter
☐ Oxygen at ____LPM ☐ Dementia ☐ Aide required at home

Physician Name: ________________ Physician Signature: ________________ Date: _______

Form date: 7/1/2018