SOUTH ATLANTA PULMONARY & CRITICAL CARE ASSOCIATES, L.L.C.
AND
CENTER FOR SLEEP MEDICINE

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Board Certified in Internal Medicine

PULMONARY DISEASES
SLEEP MEDICINE
PULMONARY REHAB

Sleep Studies Referral Form

Date: _____

Name: _____ **Sex:** _____ **Date of Birth:** _____ **Age:** _____

Referring Physician: _____ **Phone:** _____ **Fax:** _____

Requesting Physicians Address: _____

History of sleep problems:

_____Loud snoring _____Non-restorative sleep _____Observed apnea episodes
_____Excessive daytime somnolence _____Limb restlessness or jerks _____Sleep paralysis or cataplexy
_____Difficulty initiating sleep _____Hypnogogic hallucination _____Early AM awakening
_____Shift worker or irregular sleep hours

Patient Medical History:

_____HTN _____CVA _____ALS _____CHF _____TIA _____GERD
_____Asthma/COPD _____ Seizures

Physical Exam: HEENT: Height: _____ Weight: _____lbs. BMI _____ B/P _____ Pulse _____ Temp _____ RR _____

Nasopharnyx: _____ Oropharnyx: _____
Jaw/Mouth: _____ Tongue: _____
Dentition/Mucosa: _____ Neck: _____
Heart/Lungs: _____ Neurologic Exam: _____

Suspected Diagnosis:

_____Obstructive Sleep Apnea _____Narcolepsy _____ Seizures _____ PLMD/Restless Legs
_____ALS _____ Sleep Walking/RBD _____ Shift Work _____ Insomnia

Test(s) requested and study parameters:

_____Polysomnogram (psg) _____Splitnight study _____CPAP/BIPAP titration _____MSLT/MWT
_____Seizure Protocol _____ Other: _____
_____Begin oxygen prior to study if room air saturation is less than 85%
_____May supplement oxygen up to 5 LPM to maintain saturation >90%

Signature of Requesting Physician: _____

Address: _____

To schedule sleep studies please call Jill at 770-991-3888
When scheduling patients for sleep studies, please fax demographics and insurance to 770-994-0278