DALLAS SLEEP
The Dallas Center For Sleep Disorders
Adults & Pediatrics

FAX REFERRAL FORM
Fax to: 972.473.7750

SELECT LOCATION BELOW:

☐ **Plano**
Ph: 972.473.7300
6313 Preston Rd, #400
Plano, TX 75024

☐ **Dallas**
Ph: 469.726.2208
11617 N. Central Expy, #250
Dallas, TX 75243

☐ **Flower Mound**
Ph: 972.473.7300
2560 Central Park Ave., Ste 340
Flower Mound, TX 75028

☐ **McKinney**
Ph: 972.473.7300
2251 W. Eldorado Pkwy., Ste 150
McKinney, TX 75070

☐ **Southlake/Colleyville**
Ph: 972.473.7300
175 Miron Dr.
Southlake, TX 76092

PATIENT INFORMATION

Name _____ Home Phone _____ DOB _____

Street Address _____ Cell/Work Phone _____ M/F _____

City, State, Zip _____ Email address _____

Insurance _____ Insurance ID # _____

Subscriber _____ SS # _____

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.

❑ **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 Testing (HST)**
➥ Includes performing HST for qualified patients, post study consult and PAP therapy initiation (if indicated).

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

❑ **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.

❑ **Home Sleep Testing (HST)**
➥ Full night HST.

❑ **CPAP or Bilevel 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.

FOR ALL REFERRED PATIENTS, PLEASE SEND COPY OF INSURANCE AND DEMOGRAPHICS.
FOR PATIENTS REFERRED FOR SLEEP STUDY ONLY, A RECENT H&P OR MEDICAL PROGRESS NOTE IS REQUIRED.

MEDICAL HISTORY

Suspected disorder(s)
❑ Obstructive sleep apnea (OSA)
❑ Narcolepsy
❑ Nocturnal seizures/parasomnias
❑ Insomnia
❑ Restless legs syndrome (RLS)
❑ Periodic limb movements of sleep (PLMs)
❑ Idiopathic hypersomnia

Primary Symptoms
❑ Snoring/gasping/choking
❑ Witnessed apneas
❑ Frequent awakenings
❑ Difficulty falling asleep
❑ Daytime sleepiness
❑ Excessive movements of sleep
❑ Chest palpitations
❑ Attention deficit
❑ Enuresis
❑ Memory problems
❑ Headaches

Associated Medical History
❑ Hypertension
❑ Heart disease/arrhythmias
❑ Congestive heart failure
❑ Stroke
❑ Diabetes
❑ Hypothyroidism
❑ Obesity/overweight
❑ GERD
❑ Depressive mood/fibromyalgia
❑ Anxiety disorder
❑ Chronic nasal allergies/asthma

Special Needs
❑ Nocturnal O2
❑ Interpreter
❑ Disabled
❑ Wheelchair
❑ Currently on PAP
❑ Other: _____

Comments: _____

REFERRING PHYSICIAN INFORMATION

Name _____ Phone _____

Street Address _____ Fax _____

City, State, Zip _____

Physician's Signature _____ Date _____