

Baltimore Sleep and Wellness Center

Referral Form

6830 Hospital Drive
Suite 106A
Rosedale, MD 21237

3029 Dundalk Avenue
Suite 100
Baltimore, MD 21222

TEL (410)284-3020
FAX (410)284-7204

PATIENT INFORMATION:

Last Name: _____ First Name: _____ MI: ____ Gender: M F
Date of Birth: _____ Social Security #: _____ Marital Status: S M D W
Street Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

RELEVANT MEDICAL HISTORY (Please fax/send most recent office notes and sleep study)

Medications: _____
Primary Symptoms: Witnessed apneas Frequent snoring Excessive daytime sleepiness
 Obesity Large neck Difficulty falling asleep Frequent leg movements during sleep
Comments: _____
Special Needs: Nocturnal Oxygen Wheelchair Interpreter Companion accomodations
Other: _____

SUSPECTED DISORDERS (Check all that apply):

Obstructive Sleep Apnea Narcolepsy/Hypersomnia Periodic Limb Movements of Sleep
 Nocturnal Seizures/Parasomnias Insomnia Other: _____

PATIENT IS BEING REFERRED FOR (Check all that apply):

Complete Sleep Study – Provide a complete diagnostic sleep study, with treatment (PAP titration) study if recommended following completion of diagnostic study. Provide patient with CPAP/BiPAP at recommended settings if indicated. Provide patient with follow-up to discuss results of sleep studies. Provide patient with treatment follow-up through CPAP clinics.

Sleep Study – Provide patient with study selected below. Further tests to be ordered by referring physician.

- Diagnostic PSG Study
- Split-Night PSG Study
- CPAP/BiPAP Titration Study – Special instructions: _____
- Multiple Sleep Latency Test
- Maintenance of Wakefulness Test
 - CPAP clinic referral for compliance monitoring management and education.
 - CPAP desensitization (claustrophobia)

Oral Appliance therapy

- CPAP intolerant patient with Sleep apnea referred for consultation with dental specialist **Dr. Anahita Abdehou D.D.S** for customized oral appliance therapy within our center.
- Patient with primary snoring referred for consultation for customized stop snoring device.

INSURANCE INFORMATION:

Please fax/send copies of patient's primary and secondary insurance cards.

REFERRING PHYSICIAN INFORMATION:

Printed Name: _____ Phone: _____ Fax: _____
Street Address: _____ City: _____ State: _____ Zip: _____
UPIN #: _____ Group Name: _____ Specialty: _____

Physician Signature: _____ Date: _____