Erlanger North
SLEEP DISORDERS CENTER
628 MORRISON SPRINGS ROAD, Ste. 300
CHATTANOOGA, TENNESSEE 37415
423.778.3316 / 423.778.3485
Sleep Disorders Direct Referral Form

TODAYS DATE: _____

PATIENT NAME: _____

PHONE: _____

DOB: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

INSURANCE: _____

POLICY #: _____

DIAGNOSIS CODE: _____

FOR SLEEP LAB USE ONLY

_____ _____

Sleep Specialist **Date / Time**

INDICATIONS for Sleep Apnea Testing

STOP-BANG assessment tool for sleep apnea

- ☐ **S**noring, loud
- ☐ **T**iredness / fatigue / daytime sleepiness
- ☐ **O**bserved apnea
- ☐ **P**ressure: Hypertension
- ☐ **B**ody mass index (BMI) greater than 35?
- ☐ **A**ge older than 50?
- ☐ **N**eck circumference greater than 16 inches (if female) or 17 inches (if male)
- ☐ **G**ender = male?

Other associated symptoms and conditions

- ☐ Sensitive occupation: _____
- ☐ Chronic opioid use: _____
- ☐ Atrial fibrillation or other dysrhythmia: _____
- ☐ Cardiovascular disease: _____
- ☐ Neurological disease: _____
- ☐ Related airway anatomy findings: _____
- ☐ Metabolic syndrome
- ☐ Type 2 Diabetes
- ☐ Chronic lung disease: _____
- ☐ Other: _____

Nocturnal oximetry testing (Please attach if done)
Baseline O2 SAT: _____ Lowest O2 SAT: _____
Desat index: _____

Other symptoms and concerns (attach other sleep questionnaires, if used, or additional clinical information)

CONSULTS AND TESTS

SLEEP CONSULTATION / MANAGEMENT

- ☐ **Sleep Consultation and Management:** Sleep Specialist to manage testing, treatment, and follow-up

SLEEP TESTING: Select option(s) below

- ☐ **Diagnostic full-night polysomnography** (No CPAP)
- ☐ **Split-night polysomnography** (Use of American Association of Sleep Medicine (AASM) criteria recommended)
- ☐ **Full night of CPAP (**Patient must have documented diagnosis of OSA by PSG; if no diagnostic PSG, consider repeat PSG, split-night, or sleep consult)

Reason for full-night CPAP: _____

- ☐ **Home sleep test (HST)**
- ☐ **Other:** _____

Please fax this form, demographics and clinical notes supporting need for sleep study to 423-778-3485.***

Note: If needed, please prescribe **sleep aid** prior to study and instruct patient to bring to sleep lab.

SPECIAL NEEDS

- ☐ **Falls risk:** _____
- ☐ **Language barrier:** _____
- ☐ **Other:** _____

URGENCY for CONSULT / TESTING

- ☐ **Not urgent**
- ☐ **Urgent due to (**Please circle):
  Driving risk / Severe hypoxemia / Job sensitive

REFERRING PHYSICIAN: _____ **Phone:** _____ **Fax:** _____

SIGNATURE: _____ **Date:** _____