

KESWICK SLEEP INSTITUTE, INC.

PHYSICIAN REFERRAL FORM

Tel: 434-872-0222

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www.keswicksleepinstitute.com



Patient Information: *Please print*

Name: _____ Home Phone: _____ DOB: _____

Street Address: _____ Work/Cell phone: _____ M/F: _____

City, State, Zip: _____ Email: _____

Insurance: _____ ID# _____ Subscriber: _____

Services Requested:

- Comprehensive Sleep Evaluation with Diplomate of American Board of Sleep Medicine** *recommended for insomnia*
- Sleep Study & Treatment** *sleep study, post-study consult. CPAP therapy if indicated. CPAP follow-up*
- Sleep Study Only**
 - Diagnostic Sleep Study** *full night PSG*
 - Split Night Sleep Study** *full night study; 1st part diagnostic, 2nd part CPAP titration if sufficient breathing abnormalities are noted in first 3 hrs*
- CPAP Titration / BIPAP Titration** *full night titration with documented sleep apnea*
- Multiple Sleep Latency Test** *daytime nap test following a full night diagnostic PSG to diagnose excessive daytime sleepiness or narcolepsy*
- CPAP Therapy** *evaluation and training, equipment assessment, mask fitting, compliance issues*
- Maintenance of Wakefulness Test** *determine daytime vigilance*

Required:
History of
hypothyroid
yes____no____

(Southern
Health and
Trigon Ins.
order TSH)
TSH _____
Date _____

Medical History: *Please forward most recent H&P*

Prior PSG? No / Yes Date: _____ (please attach copy)

Sleep symptoms/ Suspected disorders:

- Sleep apnea
- Daytime sleepiness
- Shiftwork problems / Sleep schedule disorder
- Insomnia / Fragmented Sleep / Difficulty falling asleep
- Snoring
- Leg movements/discomfort
- Morning headaches
- Unusual behaviors during sleep
- Other _____

Medical history:

- Anemia
- HTN
- Stroke
- CHF
- GERD
- Diabetes
- COPD/Asthma
- Seizures
- Other _____

Medications: _____

*Special
needs:* _____

Name: _____

Address: _____

City, State & Zip: _____

Phone: _____ Fax: _____

Email: _____

Name: _____

Address: _____

City, State & Zip: _____

Phone: _____ Fax: _____

Email: _____

Physician's Signature: _____ Date: _____

****Please attach a copy of H&P, most recent office notes or fill in Medical History (see above section)***