Indiana Sleep Center
701 E. COUNTY LINE ROAD, SUITE 207. GREENWOOD, IN. 46143
OFFICE317-887-6400 FAX 317-887-6500 indianasleepcenter.com

REFERRAL FOR SLEEP EVALUATION

Patient Name:_____ Phone:_____

I would like for my patient to be seen in Sleep Medicine consultation and managed by the sleep physician. □Yes □ No

If "YES" is checked disregard the following and simply sign/print name below (we will then address all the required items listed for you and your staff)

If you would like to manage your patient, please provide the following:

- **RECENT NARRATIVE OFFICE NOTE**
  The note should address the indication for sleep testing and supporting medical history.
  - **Signs and symptoms of presumptive sleep disorder such as snoring, daytime sleepiness, or observed apneas**
  - **Any known comorbid conditions such as Hypertension, Cardiac Arrhythmias, Hx. Stroke or Mood Disorders**
- **SLEEP QUESTIONNAIRE**
  Please provide one of the following:
  - **Epworth Sleepiness Scale**
  - **STOP - BANG questionnaire**
  - **Berlin questionnaire**
- **CURRENT MEDICATION LIST**
- **TYPE OF STUDY**
  - **Polysomnogram**
  - **Polysomnogram with Positive Airway Pressure**
  - **Polysomnogram with Multiple Sleep Latency Test**
  - **Other:_____.**

*Please note that our accrediting body **requires** the above information be completed **prior** to determining and performing the appropriate study. If such information is unavailable from your office, we will then make arrangements to see your patient in consultation to complete the required documentation.*

Physician Signature: _____Date:_____

Please print Physician Name: _____ Phone_____

We, at the ISC, thank you for the opportunity to participate in the care of your patients.

AASM ACCREDITED Facility Member™