عيادة اضطرابات النوم التخصصية
Sleep DISORDERS SPECIALIZED Clinic

REFERRAL FORM

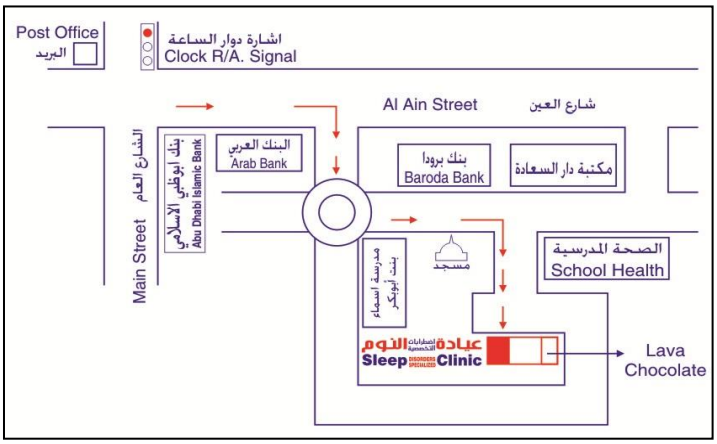
Date: _____

Patient's Full Name: _____

Age: _____, Gender: ☐ Male ☐ Female

Mobile phone: _____

Home phone: _____



Referral Options:

☐ Consultation
☐ Pulmonary Function Tests
- ☐ Spirometry
- ☐ Pre and Post Bronchodilator
- ☐ 6-minute Walk Test

☐ Consultation and Sleep study (if indicated)
☐ Sleep studies
- ☐ Sleep Study only
- ☐ CPAP titration (diagnosis already established)

(MSLT, MWT, Bi-level titration studies will require consultations)

History of Sleep Problem:

☐ Snoring
☐ Witnessed Apneas
☐ Excessive Daytime Sleepiness
☐ Nocturia
☐ Stop Bang _____

☐ Insomnia
☐ Frequent Awakenings
☐ Restless Legs Syndrome
☐ Periodic Limb Movement Disorder
☐ ESS_____

☐ Shift Work
☐ Cataplexy
☐ Sleepwalking/Nightmare
☐ Other: _____

Medical Conditions:

☐ MI/CAD ☐ Seizures/Epilepsy ☐ GERD ☐ Fibromyalgia ☐ Mood Disorder
☐ Hypertension ☐ Anxiety Disorder ☐ Chronic Pain ☐ Stroke ☐ Asthma
☐ Diabetes ☐ CHF ☐ Cardiac Arrhythmia ☐ Smoker ☐ COPD
☐ Interstitial Lung Disease

☐ Other medical condition: _____

Medications: _____

_____

Physical Exam – Positive Findings Weight: _____ Kg Height: _____ cm Neck Circumference: _____ cm

☐Tonsil enlargement :_____ ☐ Adenoid enlargement:_____

_____

Special Instructions (please check all that apply)

☐ Oxygen ☐ Patient will come with his/her caregiver ☐ others:_____
☐ Wheel chair

Referring Physician: _____ Signature and Stamp: _____

Phone:_____ Fax_____ Email address:_____