Niagara Neurology and Sleep Medicine PLLC

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PLEASE FAX THIS FORM WITH DEMOGRAPHICS TO: (716) 242-0611. THANK YOU!

SLEEP MEDICINE REFERRAL FORM

Patient referred to: Niagara Neurology / Dr. Halliwell, M.D. and Lindsay Mandrino, PA

Patient name: _____ **DOB:** _____ **Preferred DME:** _____

We recommend a consultation prior to any sleep testing or repeat sleep testing.

_____- **Consultation and management of sleep related issue(s).**

Please indicate if you have a preference for Home Sleep Testing or In-lab Testing:
We will do our best to follow your preference; this may depend on insurance, testing availability, medical co-morbidities or patient preference.

_____**- Home Sleep Testing** _____**-In-lab Testing**

I am concerned about the following condition(s):

_____- obstructive sleep apnea G47.33
_____- restless legs syndrome G25.81
_____- circadian rhythm disorder G47.20 such as shift work disorder G47.26
_____- please try to clear for safe driving from a sleep medicine perspective. (This will likely require extensive testing, patient compliance, and clinic monitoring).
_____- Other: _____

_____- insomnia G47.01 or insufficient sleep
_____- excessive sleepiness G47.10 or narcolepsy G47.41

Please check any clinical symptoms:

_____- excessive daytime sleepiness
_____- snoring
_____- witnessed apneas
_____- insomnia
_____- cognitive difficulty related to sleepiness
_____- morning headaches
_____- frequent nocturnal urination (nocturia)
_____- restless legs
_____- parasomnia (sleep walking)

Please check any associated medical conditions:

_____- hypertension I10
_____- diabetes E08.4
_____- CAD I25.1
_____- CHF I50.9
_____- arrhythmia I49.9/ atrial fibrillation I48.91
_____- Stroke I63.30 / TIA G45.9
_____- obesity (BMI >30) E66.9
_____- upper airway abnormalities J44.9
_____- neuromuscular disease G71.0

_____ _____ _____
Provider name printed or stamped **Signature** **Date**

HST home sleep study disclaimer:

HST Pros: May be more comfortable for the patient. In a situation where your patient cannot or simply will not attend in-lab sleep testing, HST will likely still allow for diagnosis and treatment of sleep apnea.
HST Cons: Less accurate than in-lab testing and less able to demonstrate severity and type of sleep apnea. Lacks information such as staging of sleep (for example showing REM sleep), exact amount of sleep and/or awakenings, length of breathing pauses, type of breathing events, limb movements, nocturnal behaviors, seizure activity, etc. Medicaid will not allow HST studies. Patients will still need in-lab CPAP titrations to accurately initiate CPAP therapy. Relative contraindications to home testing (It is recommended that people with the following chose in-lab PSG instead of HST):Age 18 YO or younger, moderate to severe COPD or moderate to severe CHF, if patient has a difficult time understanding instructions or is physically unable to

self-apply the testing equipment, suspected central sleep apnea, periodic limb movement disorder (related to RLS), suspected narcolepsy or idiopathic hypersomnia, parasomnia (sleep walking, RSBD, etc), or nocturnal seizures, already failed 2 prior HST attempts or OSA is still suspected after 2 nights of HST results are WNL, the patient is oxygen dependent for any reason, chronic opiate pain medications are used, or BMI >33 (increases risk of hypoventilation syndrome).