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Island Hospital Sleep Wellness Center

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FAAP, Sub-specialty Boards in Sleep Medicine
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Patient Information

Name: _____ D.O.B. _____

Phone: (Home) _____ (Cell) _____

Referring Provider: _____ Phone: _____

Fax: _____

Ordering Provider Section (Please Check):

Signs/Symptom:

- | | |
|---|--|
| <input type="checkbox"/> Witnessed Apnea | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Daytime Sleepiness | <input type="checkbox"/> Pulmonary HTN |
| <input type="checkbox"/> High B/P | <input type="checkbox"/> Restless Sleeper |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Morning Headaches |
| <input type="checkbox"/> Sleepy Driving | <input type="checkbox"/> CHF |
| <input type="checkbox"/> Other | |

Diagnosis for Test:

- ☐ G47.33 Sleep Apnea, Unspecified
- ☐ G47.411 Narcolepsy
- ☐ F51.01 Insomnia
- ☐ Other: _____

Service Requested:

- ☐ Sleep Center Consultation ☐ Home Sleep Study (HST)

All of the following information must be faxed to us before a patient can be scheduled:

- ___ This form completed and signed
- ___ Patient's complete H&P
- ___ Patient's demographics and insurance
- ___ Neck Circumference