200A East 62nd Street
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remsleepnyc.com

REM SLEEP
Sleep Well. Live Well.

LEXINGTON MEDICAL SERVICES, PLLC
Sleep Disorders Center

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REQUEST FOR SLEEP STUDY/REFERRAL FORM

Appointment Date

Patient Information:

Name: D.O.B.: / / Sex: M F

Address: EMail:

City: State: Zip:

Home Phone: Work Phone: Cell/Other:

Height: Weight: Blood Pressure:

Insurance Information:

Insurance Name: ID#:

Insurance Telephone Number (Provider Services):

*Please note our office may need to contact you to request additional medical documentation in order to obtain pre-authorization from the patient's insurance company.

Service Requested:

__ Comprehensive Sleep Evaluation & Follow Up (with a Sleep Physician before and/or after the study)
__ Nocturnal Polysomnogram-Diagnostic Sleep Study
__ CPAP/BPAP (Bilevel) Titration
__ Split Night Study (Combined Diagnostic & CPAP Titration)
__ MSLT
__ MWT
__ Nutritional Consultation
__ Psychologist

Symptoms:

__ Snoring
__ Witnessed Apnea
__ Excessive Daytime Sleepiness/Fatigue
__ Falling asleep while driving
__ Morning Headaches
__ Difficulty Initiating or Maintaining Sleep/Insomnia
__ Twitching & Jerking in Limbs/Restless Limbs
__ Difficulty Focusing/Concentrating
__ Decreased Libido
__ Other (**please specify**) _____

Medical Surgical History:

__ Asthma/COPD
__ Hypertension
__ Diabetes
__ Stroke
__ Cardiac Problems
__ Seizures
__ Anxiety/Depression
__ Obesity (Bariatric Surgery)
__ Allergies/Nasal Obstruction
__ Nasal Surgery
__ Enlarged Tonsils
__ Tonsillectomy
__ UPPP
__ Mandibular/Maxillofacial Surgery
__ Other (**please specify**) _____

Previous Diagnosis of OSA **___ YES** **___ NO** Date of Study _____
***Please send any relevant records on previous studies / surgery performed.**

Indications for Referral/Diagnosis:

__ Obstructive Sleep Apnea
__ Primary Snoring
__ Insomnia
__ Hypersomnia/Narcolepsy
__ RLS/PLMD
__ Jet Lag
__ Shift Work
__ Pre-Op
__ Other (**please specify**) _____

Medications:

Allergies:

Special Needs: __ Wheelchair Walker __ Language __ Supplemental Oxygen _____ Chaperon

Referring Physician:

Name: Specialty:

Address:

City: State: Zip:

Phone: Fax: Email:

NPI#: Signature :

CC:

For internal use - Approved by: _____ Medical Director Sleep Disorders Center

Rev. No. 0 27740481B