Sleep Disorders Center @ Gwinnett Clinic

2650 Lawrenceville Suwanee Rd., Suwanee, GA 30024
Lab 678-240-2078 | Office/Records 678-226-6213 | Fax 678-240-2146

SLEEP CENTER REFERRAL FORM

Please Fax Completed Form with Office Notes to 678-240-2146

PATIENT INFORMATION

Patient's Full Name:	Gender	Date of Birth

Home	Work	Mobile

Please circle the preferred contact number above.	Okay to leave message?

HISTORY AND PHYSICAL INFORMATION

Height (in)	Weight (lbs)	Neck Size (in)	Resting BP

Known Allergies:	Medications:

****Please include medications you are prescribing for your patient to take specifically for sleep or for this study in the medication list.

DESCRIPTION OF SYMPTOMS

- ☐ Excessive Daytime Sleepiness
- ☐ Snoring
- ☐ Witnessed Apneas
- ☐ Non-restorative Sleep
- ☐ RLS
- ☐ Parasomnias

MEDICAL COMORBIDITIES OR SUSPECTED SLEEP COMORBIDITIES

- ☐ Hypertension
- ☐ COPD/Asthma
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Seizures
- ☐ Stroke
- ☐ Suspected Central Apnea
- ☐ Suspected Circadian Rhythm Disorder
- ☐ Suspected PLMS or RLS
- ☐ Suspected Parasomnias
- ☐ Suspected Narcolepsy

Mental Status: Normal /Abnormal	**Ambulatory Status:** Normal / Abnormal	**List Any Limitations** (wheelchair req., hearing, etc.)

PROVIDER ORDER

- ☐ Diagnostic Polysomnogram, 95810
- ☐ CPAP Titration, 95811
- ☐ Split Study, 95811 (patient must meet Center Protocol)
- ☐ Maintenance of Wakefulness Test (MWT) 95805
- ☐ Multiple Sleep Latency Test (MSLT) 95805
- ☐ Other, Please Specify:

Please Check Box that Applies:

- ☐ Consultation and Treatment provided by Sleep Center Physician (Most Patients)
- ☐ Direct Referral – Testing **WITHOUT** Consultation or Follow-Up with Sleep Center Physician. Select this only if a qualified sleep physician outside of the Sleep Disorders Center @ Gwinnett Clinic will interpret testing results.

PROVIDER INFORMATION

Office Contact Name:	Phone:	Fax:

Provider Name	Provider Signature

Medical Director_________________________________ **Date**____________