REFERRAL

Freedom Diagnostic Services

`Sleep Lab~

1288 W. Main Street #200
Ph 972.221.1212

Lewisville Texas 75067
Fax 972.221.8252

Name: _____ Male/Female DOB:_____

Address: _____Home # _____ Cell #: _____

Referring Physician : _____ Ph#: _____

Insurance Carrier: _____ Subscriber # _____ICD____ Ht:___ WT: ___

Presenting Symptoms:

_____ Loud Snoring
_____ Excessive daytime somnolence
_____ Observed Apneas
_____ Awakening gasping for breath
_____ Non-restorative sleep
_____ Morning headaches
_____Morning Dry Mouth
_____Fatigue
_____Sleep Paralysis
_____Leg Jerks (RLS)
_____Cataplexy / Sleep attack

Test Requested:

_____ HST
_____ Polysomnography
_____ Split Night (PSG/Titration)
_____ Titration
_____ Titration Pressure ck (for patients symptomatic already on CPAP)
_____ Other

Epworth Sleepiness Scale (if available)

0=never 1=slight chance 2=moderate chance 3=high chance

Sitting/reading: ____ Sitting inactive (theater, etc): ___ Passenger in car (hour+) ____
Watching TV: ____ Lying down/resting during day: ___ Sitting/talking: _____
Sitting after lunch quietly (no alcohol): ____ In Car while stopped in traffic: _____

Physician Signature: _____ Date: _____

NPI: _____