Provider Adult Referral Form

breathoflife • sleepmedicine

Patient Information

Name | DOB

Email | Phone

Mailing Address | Zip Code

Reason For Referral *(select all that apply)*

- ☐ Suspected Sleep Apnea Evaluation / Management
- ☐ PAP Therapy Initiation / Management (APAP, BiPAP, BiPAP ST, ASV)
- ☐ PAP Intolerance / Nonadherence
- ☐ PAP Failure Despite Optimization
- ☐ Treatment Emergent Central Sleep Apnea (TECSA)
- ☐ Sleep Study Interpretation / Second Opinion
- ☐ Inspire Hypoglossal Nerve Stimulator Evaluation / Management
- ☐ remedē Phrenic Nerve Stimulator Evaluation / Management
- ☐ Evaluation for Alternative Therapy Options for Snoring / Sleep Apnea
- ☐ Other (please describe in Clinical Notes)

Symptoms *(select all that apply)*

- ☐ Snoring
- ☐ Witnessed Apneas
- ☐ Excessive Daytime Sleepiness
- ☐ Morning Headaches
- ☐ Unrefreshing Sleep / Fatigue / Frequent Awakenings
- ☐ Insomnia
- ☐ Mood Changes / Cognative Concerns
- ☐ Other (please describe in Clinical Notes)

Relevant History

Prior Sleep Study ○ None ○ Home Sleep Study ○ Laboratory PSG / Split Night / Titration

Date of Study | AHI | CAHI

PAP Compliance ○ Compliant ○ Non-Compliant ○ Intolerant ○ N/A

Relevant Comorbidities

- ☐ Heart Failure (please note LVEF in Cinical Notes)
- ☐ Atrial Fibrillation
- ☐ Coronary Artery Disease
- ☐ Hypertension
- ☐ Stroke / TIA History
- ☐ Opioid Use
- ☐ Other (please describe in Clinical Notes)

Prior/Current Therapies

- ☐ CPAP
- ☐ BiPAP
- ☐ ASV or BiPAP ST
- ☐ Oral Appliance
- ☐ Hypoglossal Nerve Stimulation (HGNS)
- ☐ Transvenous Phrenic Nerve Stimulation (TPNS)
- ☐ Positional Therapy
- ☐ Surgical Intervention (please specify in Cinical Notes)
- ☐ None / Treatment-Naive

Preferred Office Location

○ ***Coeur d'Alene***
1717 Lincoln Way STE 201
Coeur d'Alene ID 83814
Airway Institute

○ ***Spokane Valley***
12410 E Sinto Ave STE D
Spokane Valley WA 99216
Aspen Sleep Centers

○ ***No preference***

Clinical Notes

Items to Include

Please include the following items when submitting the referral form.

- Patient face sheet / demographics page
- Copy of the patient's insurance card(s) front and back
- Insurance authorization (if required)
- Copy of valid photo ID
- Relevant medical records, sleep studies, PAP download, echocardiogram, medication list, recent clinic notes

Referring Provider

Name | ☐ Phone

☐ Email | ☐ Fax

Referring Provider Signature | Date