WATERSTONE
Sleep & Neuroscience Associates

REQUEST FOR SLEEP MEDICINE REFERRAL

Tel: 203-245-0412 www.sleepwellmd.com Fax: 203-427-0441

PATIENT INFORMATION				
LAST:	FIRST:	MALE ☐	FEMALE ☐	DATE OF BIRTH:
ADDRESS:				
HOME TELEPHONE:	CELL:	WORK NUMBER:		
INSURANCE CARRIER:	INSURANCE ID #:			

TYPE OF VISIT/TEST REQUESTED
☐ Comprehensive Sleep Evaluation (Consultation & Sleep Study)
☐ Sleep Study Only
☐ CPAP Titration
☐ Split-night Study
☐ Multiple Sleep Latency to Rule Out Narcolepsy (PSG + MSLT)
☐ Cognitive Behavioral Therapy (CBT)
☐ CPAP Acclimatization (PAP-NAP)
☐ Home Sleep Test

Please complete this form and fax to 203-427-0441. We will contact the patient directly to schedule an appointment.

SUSPECTED SLEEP DISORDER		
☐ Sleep Apnea	☐ Restless Leg Syndrome	☐ Insomnia
☐ Narcolepsy	☐ Circadian Rhythm Sleep Disorder	☐ Parasomnia
☐ Hypersomnia	☐ Periodic Limb Movement Disorder	☐ Other _____

PATIENT COMPLAINTS	**CURRENT DIAGNOSIS**		**SPECIAL NEEDS**
☐ Snoring	☐ Obesity	☐ OSA	☐ On Oxygen at _____L/min
☐ Witness Apnea	☐ Hypertension	☐ Stroke	☐ Wheelchair
☐ Excessive Daytime Sleepiness	☐ Anxiety/Depression	☐ Diabetes	☐ Language Interpreter
☐ Morning Headache	☐ GERD	☐ Asthma/COPD	☐ On CPAP/BiPAP at Home
☐ Involuntary Limb Movements	☐ CAD/CHF	☐ Headache	☐ Patient coming with aide
☐ Sleepwalking/talking	☐ Arrhythmia	☐ Seizure Disorder	☐ Other _____
☐ Insomnia	☐ Other _____		
☐ Other _____			

ADDITIONAL PATIENT INFORMATION		
Height ____ft.____in.	Weight _____lbs.	Blood Pressure _____/_____
Current Medications:		
Allergies:		
Is patient currently on CPAP? ☐ No ☐ Yes If yes, CPAP pressure_____cm		
Has patient had prior sleep studies? ☐ No ☐ Yes (please send copy of report if possible)		

REFFERING PHYSICIAN		
Name:	Phone:	Fax:
Office Address:		
Signature: _____	Date: _____	

REPORT PREFERENCES		
☐ Telephone Call	☐ By Mail	☐ By Fax

OFFICE LOCATIONS

32 Wall St, Ste C, Madison, CT 06443 | 3190 Whitney Ave, Bldg 6, Hamden, CT 06518 | 400 Bayonet St, Ste 201, New London, CT 06320