

Wake Sleep

Sleep Disorders Center

Office: 919-645-9280
Fax: 919-208-2149
wakesleeplab.com

3100 Duraleigh Rd
Ste 302
Raleigh, NC 27612

Sleep Laboratory Referral Form

Patient Name _____ Home Phone _____
Address _____ Work Phone _____
_____ Cell Phone _____
Insurance _____ Date of Birth _____

Sleep Service Requested: Sleep Consultation Polysomnogram (NPSG) CPAP Titration
(Initial sleep consult, sleep study, follow-up (Diagnostic sleep study, to include (Initial NPSG within 2 yrs)
visit and CPAP equipment if indicated) separate CPAP titration if indicated)

Split Study Multiple Sleep Latency Test Maintenance of Wakefulness Test
(Combined NPSG and titration Study if criteria met in first 2 hours)

I would like WS to perform CPAP titration if NPSG is abnormal
 I would like WS to order CPAP equipment and supplies if indicated

Referring Diagnosis: Apnea 327.23 Unexplained Drowsiness 780.54 Insomnia 780.52 Narcolepsy 347.00
 Restless Leg Syndrome 333.99 Unspecified Sleep Disturbance 780.50 Other _____

Indications: Witnessed Apneas Daytime Fatigue Restless Sleep Obesity Snoring
 Frequent Napping Poor Memory Irritability Morning Headaches Enlarged Tonsils
 Hypersomnolence

Medical History: Hypertension Allergies Deviated Septum Cardiac Problems Obesity
 Diabetes Seizures Enlarged Tongue Other _____

Special Needs: Wheelchair Walker O₂ Other _____

Referring Physician: _____

Practice: _____ **Phone:** _____ **Fax:** _____

Physicians Signature: _____

I Authorize WS to perform sleep studies on above patient according to their protocols, including urgent initiation of O₂ and/or CPAP

Person to contact with any questions regarding this referral: _____

Internal Use Only: Practice _____
Received ___/___/___ WS Chart # _____
Faxed Appt Conf. ___/___/___

Please complete and fax to 919-208-2149 along with insurance card, recent chart note or medical history