Legacy Sleep Center

Physician Referral Form

Check one location for your referral

- ○ Legacy Good Samaritan • Phone: 503-413-7540 • Fax: 503-413-6919
- ○ Legacy Meridian Park • Phone: 503-692-7855 • Fax: 503-692-7336
- ○ Legacy Mount Hood • Phone: 503-413-7540 • Fax: 503-413-6919
- ○ Legacy Salmon Creek • Phone: 360-487-4707 • Fax: 360-487-4709

Patient name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Insurance _____ Insurance authorization # _____

Please attach a copy of insurance card, demographic information, history and physical, chart notes with indication for sleep study, problem list, medication list and significant allergies. These items are required to schedule a sleep study.

Indications for Sleep Study Referral

☐ Snoring	☐ Bariatric Surgery	☐ Parasomnia	☐ Hypertension
☐ Observed Apnea	☐ Hypercarbia	☐ Insomnia	☐ Narcolepsy
☐ Excessive Daytime Sleepiness	☐ Atrial Fibrillation	☐ REM Behavior Disorder	☐ Diabetes
☐ RLS/PLIVD	☐ CAD	☐ Seizures	☐ Prior History of OSA
☐ Abnormal Movements	☐ Bruxism	☐ Complex Sleep Apnea	

☐ Other (please specify) _____

Referral Options

☐ **Sleep Specialist Consultation:**

☐ **Diagnostic Testing Only:** No CPAP/BILEVEL

☐ **Split Night Study:** Diagnostic + CPAP/BILEVEL Titration if indicated. PAP therapy will be ordered for patients meeting insurance and Sleep Center criteria.

☐ **CPAP/BILEVEL Titration:** Must provide prior sleep study. PAP therapy will be ordered for patients meeting insurance and Sleep Center criteria.

☐ **Home Sleep Study:** Requires a Sleep Specialist consultation. (LGS and LMP only)

☐ **Actigraphy:** (LGS only)

Other Services: These studies require a Sleep Specialist consultation. (MSLT and MWT require urine toxicology screen)

☐ **MSLT** ☐ **MWT** ☐ **ASV Titration** ☐ **AVAPS Titration** ☐ **Parasomnia/REM Behavior Study** ☐ **Seizure Study**

Medication

If a sleep aid is indicated, please provide for patient before coming to the Sleep Center. Ambien is the preferred medication.

Note: By signing below, I signify that the patient has been deemed capable of self-administering his or her own medications.

Oxygen Administration

Oxygen will be administered per Sleep Center protocol. Patient currently on home O2 at _____ lpm.

☐ ABG pre-study (LGS and LMP only) ☐ ABG post-study (LGS and LMP only) (ABGs may also be drawn per Sleep Center protocol)

Special instructions

_____

Referring physician _____ Phone _____ Fax _____

Address _____ City _____ State _____ Zip _____

Physician signature _____ Date _____

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