Legacy Sleep Center

Physician Referral Form

Patient name _____ Phone _____ Date of birth *(mm/dd/yyyy)* _____

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.

Indications for Consultation or Sleep Study:

- ☐ Snoring
- ☐ Observed apnea
- ☐ Excessive daytime sleepiness
- ☐ RLS/PLIVD
- ☐ Abnormal movements
- ☐ Bariatric surgery
- ☐ Hypercarbia
- ☐ Atrial fibrillation
- ☐ CAD
- ☐ Bruxism
- ☐ Parasomnia
- ☐ Insomnia
- ☐ REM behavior disorder
- ☐ Seizures
- ☐ Complex sleep apnea
- ☐ Hypertension
- ☐ Narcolepsy
- ☐ Diabetes
- ☐ Prior history of OSA
- ☐ Other (please specify) _____

Please refer for a Consultation *OR* a Sleep Study:

Sleep Specialist Consultation Referral (see reverse for specialists' office addresses and fax numbers):

- ○ Jeffrey Bluhm, M.D. (Legacy Meridian Park)
- ○ Beenish Khwaja, D.O. (Legacy Mount Hood)
- ○ Poh Leng, M.D. (Legacy Good Samaritan, Legacy Salmon Creek)
- ○ David Liss, M.D. (Legacy Meridian Park)
- ○ Joshua Ramseyer, M.D. (Legacy Good Samaritan, Legacy Meridian Park)
- ○ Jody Tate, M.D. (Legacy Salmon Creek, Legacy Meridian Park, Legacy Mount Hood)

Sleep Study Referral:

- ○ Legacy Good Samaritan — Fax: **503-413-6919**
- ○ Legacy Meridian Park — Fax: **503-692-7336**
- ○ Legacy Mount Hood — Fax: **503-413-6919**
- ○ Legacy Salmon Creek — Fax: **360-487-4709**

○ **Split night study:** Diagnostic + CPAP/BILEVEL titration if insurance and Sleep Center criteria met

○ **Diagnostic testing only:** No CPAP/BILEVEL

○ **CPAP/BILEVEL titration:** Must provide prior sleep study

Also available — These studies require a sleep specialist consultation — please complete consultation section above:

- Home sleep study
- MSLT
- MWT
- ASV Titration
- Parasomnia/REM behavior study
- Seizure study
- Actigraphy
- PAP-NAP

Medications needed for Sleep Study:

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

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 needs (e.g., equipment, language needs): _____

Referring physician _____ Phone _____ Fax _____

Address _____ City _____ State _____ Zip _____

Physician signature _____ Date _____

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Jeffrey Bluhm, M.D.

Oregon Pulmonary Associates

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Beenish Khwaja, D.O.

Legacy Medical Group–Sleep Medicine at Mount Hood

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For complete information about Legacy Sleep Services, please visit **www.legacyhealth.org/sleep**, or in Oregon call **503-413-REST (7378)** or in Washington **360-48-SLEEP (75337)**.