BRISTOL HOSPITAL
Sleep Center

41 Brewster Road
Level E
Bristol, CT 06010

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Patient Information (Required)

Patient Name: _____ Birth Date: _____

Address: _____ (street) _____ (city) _____ (zip code) _____

Home Phone: _____ Day Phone: _____ Cell Phone: _____

Best Number To Be Reached At: _____ Best Time To Call: _____

Primary Insurance: _____ Co-Insurance: _____

Subscriber Name: _____ Subscriber Name: _____

Subscriber #: _____ Subscriber #: _____

Service Request:

- ☐ Sleep Consult (recommended for all referring physicians) - Testing, follow-up, treatment by sleep physician.
- ☐ Testing only (Referring physician orders test, treatment, and follow-up)
- ☐ Testing followed by consult if testing is positive.

Type of testing: (Select only if testing applies)

- ☐ Split Night
- ☐ Diagnostic Polysomnography
- ☐ CPAP Titration Study Only.
- ☐ Polysomnogram followed by MSLT
- ☐ MWT
- ☐ Home Sleep Test (Choose if patient has no Pulmonary/Cardiac/Neurological issues.)

Indication For Sleep Study (Required Information):

☐ Snoring ☐ Day time sleepiness ☐ Nocturnal sleep disruptions ☐ Morning headache
☐ Observed apnea or gasping ☐ Shift work disorder ☐ Insomnia ☐ Other: _____

Health Information

Past Medical History: (include arrhythmias and cardio pulmonary history) *Please include additional sheet of paper if necessary*: _____

_____

Submit a copy of a physical exam OR complete the section below. *Please note: A medical history and physical exam of patients referred for sleep testing is required for ASSM accreditation.*

Blood Pressure ____/____ Height _____ Weight _____ BMI _____

	Normal	Abnormal	Describe
Nasal Airway	☐	☐	_____
Oropharynx (palate, uvula, tonsils)	☐	☐	_____
Maxillo mandibular anatomy	☐	☐	_____
Cardiac	☐	☐	_____
Chest	☐	☐	_____
Neurological	☐	☐	_____

Date of Exam: _____

☐ Has the patient had a sleep study in the past? If so, please include a copy of the study as well as other relevant information to avoid a delay in the patients office visit.

Referring Physician Name: _____ Specialty: _____

Referring Physician Signature: _____ Date: _____ Time _____

Physician Phone Number: _____ Fax: _____

Sleep Center Phone: 860-585-3300 Sleep Center Fax: 860-585-3952