THE SPINE HOSPITAL OF LOUISIANA
at The NeuroMedical Center

10105 Park Rowe Circle
Baton Rouge, LA 70810
Phone: 225-763-9900
Fax: 225-906-4839
TheNeuroMedicalCenter.com

The Spine Hospital of Louisiana Sleep Center
REFERRAL FOR SLEEP STUDY
FAX TO ADMISSIONS AT 906-4840

PERSONAL INFORMATION

Name: _____ Home Phone: _____
Birth Date: _____ Social Security # _____ Work Phone: _____
Age: _____ Height: _____ Weight: _____ BMI: _____ Gender: M / F
Sleeping Hours: From _____am/pm To: _____am/pm
Occupation: _____

Requesting Physician: _____ Phone: _____ Fax: _____

HISTORY AND PHYSICAL INFORMATION **TO BE FILLED OUT BY PHYSICIAN**

History of Sleep Problem (Check All That Apply)

_____ Excessive Daytime Sleepiness
_____ Sleep Paralysis
_____ Claustrophobia
_____ Sleepwalking
_____ Morning Headaches
_____ Snoring
_____ Shift Work
_____ Nocturnal Choking/Gasping

_____ Witnessed Apneas
_____ Insomnia
_____ Frequent Awakenings
_____ Bruxism
_____ Cataplexy
_____ Nocturia
_____ Nocturnal Restlessness
Other: _____

Car crash or near miss associated with drowsiness / excessive sleepiness YES or NO (REQUIRED)

Medical Conditions

_____ Cardiac Arrhythmias
_____ CHF
_____ ALS
_____ Stroke/Weakness
_____ Seizures

_____ GERD
_____ Diabetes
_____ Asthma/COPD
_____ Chronic Pain
_____ Fibromyalgia

_____ HTN
_____ Epworth Score
_____ Berlin Questionnaire
_____ Headaches

Physical Exam

HEENT _____
Nasopharynx _____
Oropharynx: _____
Jaw/Mouth: _____
_____
Tongue: _____
Dentition/Mucosa: _____
Neck Size in inches: _____

Heart: _____ Mental Status: _____
Lungs: _____
Mallampatti Score: I II III IV .
Neurologic Exam:

Circle Applicable Study Types: Diagnostic - CPAP/BiPAP - HST - MSLT - Split Night (if indicated)

Diagnosis Circle all that apply: PLMD/Restless Legs - Hypersomnia - ALS - Sleepwalking/RBD
Shift Work - Insomnia - Obstructive Sleep Apnea - Narcolepsy - Seizures

Special Needs: Please circle all that apply:
Oxygen: ____L/m Wheelchair Assistance Difficulty Communicating Other _____

Ordering Physician Signature: _____
Date: _____Time_____ Approved By : _____
David Thomas, M.D.
Medical Director