



THE SPINE HOSPITAL
OF
LOUISIANA
at The NeuroMedical Center

10105 Park Rowe Circle
Baton Rouge, LA 70810
Phone: 225-763-9900
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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)

- | | |
|---|---|
| <input type="checkbox"/> Excessive Daytime Sleepiness | <input type="checkbox"/> Witnessed Apneas |
| <input type="checkbox"/> Sleep Paralysis | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Claustrophobia | <input type="checkbox"/> Frequent Awakenings |
| <input type="checkbox"/> Sleepwalking | <input type="checkbox"/> Bruxism |
| <input type="checkbox"/> Morning Headaches | <input type="checkbox"/> Cataplexy |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Nocturia |
| <input type="checkbox"/> Shift Work | <input type="checkbox"/> Nocturnal Restlessness |
| <input type="checkbox"/> Nocturnal Choking/Gasping | Other: _____ |

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

Medical Conditions

- | | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> Cardiac Arrhythmias | <input type="checkbox"/> GERD | <input type="checkbox"/> HTN |
| <input type="checkbox"/> CHF | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epworth Score |
| <input type="checkbox"/> ALS | <input type="checkbox"/> Asthma/COPD | <input type="checkbox"/> Berlin Questionnaire |
| <input type="checkbox"/> Stroke/Weakness | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Fibromyalgia | |

Physical Exam

HEENT _____ Heart: _____ Mental Status: _____
Nasopharynx _____ Lungs: _____
Oropharynx: _____ Mallampatti Score: _____ I _____ II _____ III _____ IV _____
Jaw/Mouth: _____
Tongue: _____
Dentition/Mucosa: _____
Neck Size in inches: _____

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