Sleep & Attention Disorders Institute
(Accredited by American Academy of Sleep Medicine)
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Board Certified, Sleep Medicine & Clinical Neurophysiology
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Refer to R Bart Sangal, MD the following patient:

_____ _____
Patient Name Phone No. of Patient

REASON:
(_____) Adult or Pediatric Sleep Apnea (confirm diagnosis, determine severity)
(_____) Other Adult or Pediatric Sleep Disorder (such as narcolepsy, insomnia, parasomnia, etc.)
(_____) Adult or Pediatric Attention Deficit (confirm diagnosis, determine best medicine to treat)
(_____) Mild Cognitive Impairment (confirm presence, evaluate reversible causes)

I: (_____) Evaluate, then
A: (_____) test as necessary, and treat
B: (_____) test as necessary, then return to referring physician for treatment
C: (_____) test as necessary, then treat if sleep apnea, AHI > _____ (5 is default if no value entered), otherwise return to referring physician

OR

II: (_____) Test based on referring physician's evaluation, then
A: (_____) return to referring physician for treatment
B: (_____) treat if sleep apnea, AHI > _____ (5 is default if no value entered), otherwise return to referring physician

COMPLETE THIS SECTION IF SELECTING II and attach your evaluation (H&P)

Loud snoring (_____) Tired/fatigued/sleepy during day (_____)
Observed apnea in sleep (_____) High blood pressure (_____)
Age: _____ yrs Gender: (_____) Neck circumference: _____ in.
Height: _____ Weight: _____ lbs BMI (if known)_____

(_____) Home sleep testing 95806 for Obstructive Sleep Apnea, if inconclusive/unsatisfactory do follow-up polysomnography in sleep center 95810
(_____) Home sleep testing 95806 for Obstructive Sleep Apnea
(_____) Polysomnography in sleep center 95810 for Obstructive Sleep Apnea (OSA)
(_____) Polysomnography in sleep center 95810 for OSA with follow-up CPAP titration PSG (95811) if necessary
(_____) Polysomnography with CPAP titration (95811) for confirmed OSA
(_____) Polysomnography 95810 and MSLT 95805 for Narcolepsy

[If you select testing without evaluation by Dr. Sangal, we can still arrange Positive Airway Pressure device through a DME company, based upon a positive test for sleep apnea, with your prescription]

_____ _____
Signature of Referring Physician Name of Referring Physician
Date:_____ Tel No:_____

PLEASE FAX THIS FORM TO 586-254-7207 AND GIVE COPY TO PATIENT