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COLUMBIA UNIVERSITY MEDICAL CENTER
Columbia Comprehensive Sleep Disorders
Center Department of Neurology

Referral for Consultation / Testing

Name:	*MRN:*
DOB:	*Home phone:*
Address:	*Insurance:*
	Insurance Tel.#
Referring MD & Tel #	
***Reason for referral / (Suspected) Diagnoses/ Symptoms:*	*Current Medications:*
Epworth Sleepiness Score (see scoring next page): 0	

If consultation is *not* requested, please be specific about diagnostic questions, symptoms and include a copy of a completed evaluation, **all prior studies and Epworth Score

☑ **Consultation Prior to Study**
It is preferred and required by the American Academy of Sleep Medicine that patients be evaluated by a sleep specliast prior to polysomnography.

Please Note: Patients will be routinely scheduled for a followt up appointment after the sleep test to discuss the results of the evaluation.

Results will NOT be discussed by phone without prior consultation but will be sent to the referring provider

☐ **Home Sleep Test** *Patients with commercial insurance are generally required to have this prior to in-lab testing*

PLEASE NOTE: Unless the patient is under the age of 18; has co-morbid heart failure, neuromuscular disease, epilepsy; or has Medicare/Medicaid, a home sleep test is typically **required** prior to in-lab polysomnography

☐ **In-lab polysomnography**

- ☐ **With extended EEG** *Recommended for abnormal behaviors/parasomnias/nocturnal seizures*
- ☐ **With Multiple Sleep Latency Testing** *Recommended for suspected narcolepsy*
- ☐ **With titration** *To initiate treatment with PAP therapy on the same night*

NOTE: Complex cardiopulmonary cases may be sent to Robert Basner, MD at The Pulmonary Sleep Laboratory

☐ **MSLT only** *Please provide a copy of a recent sleep study with this request otherwise a PSG will be order for the prior night*

☐ **MWT only** *To assess ability to remain awake eg for commercial drivers*

For office use only:

Verification Date:	***Notes:***
Precert# /Date:	***Notes:***

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? ***This refers to your usual way of life in recent times****. Even if you have not done some of these things recently try to work out how they would have affected you.*

0 = No chance

1 = Slight chance of dozing

2 = Moderate chance of dozing

3 = High chance of dozing

Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g a theater or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
TOTAL	0 */24*