Better Sleep NEW YORK

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Bronx, NY 10461
Tel: (718) 304-7638
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Referring Physician Information

MD. Name:_____ **Phone:**_____
Address:_____ **Fax:**_____
_____ **NPI:** _____

MD Signature:_____ **Date:**_____

We will contact the patient to schedule the test(s) that you have ordered and then notify your office!

Please Fill out ALL information:

Patient's Name:_____ **Male** **Female**

Height:_____ **Weight:**_____ **DOB:**_____ **MR #:**_____

Patient's Address:_____

Tel: (cell) _____ **(home)** _____

Primary Insurance: _____ **Insurance ID**_____

SLEEP STUDY REQUEST

Study Type: ☐ **Full Service (PSG and CPAP)** ☐**PSG only (baseline)** ☐ **Split night** ☐**CPAP titration only** ☐**MSLT/MWT**

Consultations: ☐ **Sleep Specialist** ☐ **Insomnia/Behavioral Treatment Specialist** ☐ **Dietitian/Nutritionist**

Patient's Sleep History:	**Patient's Medical History:**	**Current Therapy:**
☐ **OSA**	☐ **Nasal Obstruction**	☐ **NONE**
☐ **Snoring**	☐ **Morbid Obesity**	☐ **Oxygen ____ L/min**
☐**Excessive Daytime Sleepiness**	☐ **Diabetes**	☐ **CPAP/BiPAP level _____**
☐ **Stopping breathing**	☐ **Asthma**	☐ **ASV level _____**
☐ **Gasping for air**	☐ **Heart Disease**	☐ **Medications:_____**
☐ **Insomnia**	☐ **Other_____**	_____