VCU Center for Sleep Medicine

Outside VCU Sleep Study Only - Direct Referral Form

Date:_____ Requesting Physician:_____

Physician Office Phone:_____ Fax:_____ **(Both Required)**

Patient Name:_____ DOB: _____

Height:_____

Address:_____ Weight:_____

BMI: _____

_____ Neck Cir:_____

Primary Phone:_____ Alternate Phone:_____

Primary Insurance:_____ Secondary Insurance:_____

Expiration:_____ Expiration:_____

External Referrals only:

MUST ATTACH BRIEF MEDICAL HISTORY AND RECENT OFFICE NOTES

Reason for Referral/Consultation and Medical History

- ☐ Documented HTN
- ☐ Excessive Daytime Sleepiness
- ☐ History of Stroke
- ☐ Impaired Cognitive Function
- ☐ Insomnia
- ☐ Ischemic Heart Disease
- ☐ Mood Disorder
- ☐ Heart Failure
- ☐ Loud Snoring
- ☐ Morning Headaches
- ☐ Abnormal Oximetry
- ☐ Neck Size >17" Men or >16" Women
- ☐ Neuromuscular Disease
- ☐ Obesity
- ☐ Observed Apneas
- ☐ Severe Pulmonary Disease
- ☐ Wakes Choking/Gasping
- ☐ Pulmonary Hypertension
- ☐ *Other

_____ Epworth Sleepiness Score (If Available)

* Describe Other:_____

Does your patient require any skilled nursing care, specialized medical equipment, assistance with medication, feeding administration, transfers or toileting? ☐ **Yes*** ☐ **No**

* If yes, then the patient will need to provide the necessary nurse/caregiver to assist them, as overnight we function as a stand alone testing facility and do not have pharmacy services, nurses or patient care assistants. For all pediatric patients, a parent or legal guardian must be present for the duration of the appointment. **All other visitors will be asked to leave at bedtime and will NOT be permitted to stay under any circumstances.** For further information or questions please call **(804) 323-2255**.

An appointment time will be set aside especially for your patient. **Should they fail to cancel 24 hours prior to the appointment, it will be considered a no-show and they will not be permitted to reschedule.** You as the referring physician will need to communicate with the patient and send a new referral to receive another appointment.

Physician Signature:_____ Date:_____

2529 Professional Road, Richmond, VA 23235

Ph:(804) **323-2255** | Fax:(804) 323-2262

www.vcuhealth.org/sleep

ACCREDITED MEMBER CENTER