



Box 800682
 University of Virginia Health System
 Charlottesville, VA 22908
 Phones 434-982-0407 (select option 1)
 800-251-3627 ext 42262
 Fax 434-982-0402

The Sleep Disorders Center
 Request for Consultation and Sleep Study

Patient name: _____
 History # _____ Date of birth: _____
 Reason for consultation _____
 Social Security #: _____

Please indicate whether the patient has any of the following conditions. This information is necessary in order to assign the appropriate care provider.

- _____ Severe Pulmonary disease (e.g. COPD, Pulmonary hypertension)
- _____ Severe Cardiovascular disease
- _____ Neuromuscular disease
- _____ Insomnia

Insurance companies require specific symptoms before they will approve sleep studies. Please check all symptoms this patient is experiencing.

- _____ Excessive daytime sleepiness
- _____ Falls asleep driving
- _____ Loud snoring
- _____ Observed apneas
- _____ Patient sleeps alone – no one to witness snoring or apnea
- _____ Wakes choking or gasping
- _____ Wakes up snoring
- _____ Morning headache
- _____ Hypertension
- _____ Obesity
- _____ Large neck _____ 17.5” men _____ 16” women
- _____ Ischemic heart disease
- _____ History of stroke
- _____ Mood disorder
- _____ Impaired cognitive function
- _____ Nocturnal oximetry abnormal
- _____ Other _____

REQUIRED:

History of Hypothyroidism: Yes___ No___

If Yes: Patients having **Southern Health**,
 or **Trigon** insurance, order TSH
 (call, or fax results to us)

_____ TSH Level
 _____ Date of TSH

WE NOW REQUIRE THAT PATIENTS CALL US THEMSELVES TO MAKE THEIR APPOINTMENT. This is an attempt to decrease “no shows” which increase the waiting time for other patients.

PLEASE ASK THE PATIENT TO CALL US AT EITHER 434-982-0407 OR 800-251-3627 EXT 42262 FOR AN APPOINTMENT. IF THEY GET VOICE MAIL BOX, THEY SHOULD LEAVE THEIR NAME AND PHONE NUMBER.

In addition to this form, please also fax a copy of one of the following: recent history and physical, updated problem list, current medication list. Please send a copy of the patient’s insurance card.

Referring Physician (print) _____
 Date _____