Check One

☐ **Lincoln Medical Center**
6 Blackstone Valley Place, Bldg. 7
Lincoln, RI 02865

☐ **East Greenwich Medical Center**
1407 South County Trail,
East Greenwich, RI 02818 Bldg. 4, Ste. 430

☐ **ENT Center of RI, Warwick**
55 Lambert Lind Hwy.
Warwick, RI 02886

☐ **Swansea Professional Center**
1010 GAR Highway (Rte. 6)
Swansea, MA 02777

Epoch Sleep Centers

ORDER FORM

In RI	In MA
Phone: 401-541-9188 • Referral Fax: 401-541-9199	**Phone: 508-646-4303 • Referral Fax: 508-646-4304**

www.epochsc.com

PATIENT INFORMATION

Name: _____ DOB: _____ M/F: _____

Home Phone: _____ Cell/Alt. Phone: _____

Emergency Contact: _____ Phone: _____

Primary Insurance: _____ Insurance #: _____

Suspected Disorders/Diagnosis
(Please check all that apply)

- ☐ Obstructive Sleep Apnea (OSA)
- ☐ Insomnia
- ☐ Nocturnal Seizures/parasomnia
- ☐ Restless leg syndrome (RLS) or Periodic Limb movements of sleep (PLMS)
- ☐ Narcolepsy

Primary Symptoms
(Please check all that apply)

- ☐ Snoring/gasping /choking
- ☐ Witnessed Apneas
- ☐ Obese /Large neck
- ☐ Daytime Fatigue
- ☐ Difficulty Falling Asleep
- ☐ Frequent Awakening/Fragmented Sleep
- ☐ Frequent leg movements during sleep
- ☐ S/P Airway Surgery
- ☐ Hypertension
- ☐ Depression/Mood Disorders
- ☐ Other _____

MEDICAL HISTORY
Please provide most recent clinical notes.

Past Medical History/DX

_____
_____
_____
_____
_____
_____
_____
_____

SLEEP STUDY ONLY (Please check all that apply)

- ☐ Two night protocol (Standard Polysomnography followed by PAP titration if PSG reveals patient has OSA)
- ☐ Standard polysomnography,(Full night PSG)
- ☐ CPAP/Bi-level titration, (Full night Titration for pt's with documented OSA)
- ☐ Split night study: (Full night Sleep study. First portion diagnostic and second portion apply CPAP if clinical criteria met)
- ☐ MSLT (daytime Sleep study). (Multiple Sleep Latency Test) _____MWT (daytime wakefulness sleep study)

Do you want patient to see a:

- ☐ Sleep Specialist Consultation and Management
  (Lincoln, Providence, East Greenwich, Warren RI or Dartmouth, MA)
- ☐ Oral Appliance Consultation and treatment to treat snoring and sleep apnea

Special Needs

_____
_____
_____

PROVIDER INFORMATION

Referring Physician /NP/PA Name: _____

Phone: _____ Fax: _____

Primary Care Physician Name: _____

Physician /NP/PA Signature _____ **Date** _____

FOR EPOCH SLEEP CENTER ONLY

Check if physical exam is listed in referring M.D.'s notes ☐

History reviewed by _____ M.D. Date _____/_____/_____

Revised 8/10