FusionSleep®
Sleep Medicine Program

REFERRAL FORM

Please FAX along with office notes and insurance card to **678.840.3777**

OFFICE TO COMPLETE

OFFICE CONTACT DETAILS

Name:	Phone:	Fax:

PATIENT PERSONAL INFORMATION

Last Name:	First Name:	Gender:	DOB:
Home: ☐	Work: ☐	Mobile: ☐	

Please check the best number to reach patient by phone   May we leave a message on voicemail/answering machine? YES / NO

PATIENT TO COMPLETE

EPWORTH SLEEPINESS SCALE

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. Use the following scale to choose the **most appropriate number** for each situation ● Please circle your answer ● 0 = Would never doze ● 1 = Slight chance of dozing ●2 = Moderate chance of dozing ● 3 = High chance of dozing

Situation	Chance of Dozing			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive, in a public place (e.g., a theater or a meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking with someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

PLEASE CHECK ALL THAT APPLY

- ☐ I do snore
- ☐ I have been told that I stop breathing during sleep
- ☐ Sometimes I wake up gasping for air
- ☐ Sometimes I have morning headaches
- ☐ I feel restless before or during sleep
- ☐ I have difficulty falling to or staying asleep

PROVIDER TO COMPLETE

Height:	Weight:	B/P:

MEDICAL HISTORY: ☐ See Office Notes for Details

- ☐ Hypertension
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Neurologic disorder
- ☐ Other – Please Specify

Allergies	Medications:

PRESENTING SYMPTOMS:

- ☐ Loud Snoring
- ☐ Excessive daytime somnolence
- ☐ Observed apnea
- ☐ Non-restorative sleep
- ☐ Restless Legs Syndrome (RLS)
- ☐ Parasomnias
- ☐ Other – Please Specify

▶ PROVIDER ORDER ◀

- ☐ **Consultation** by Center Physician, **Testing** and **Treatment** as required
- ☐ **Polysomnography** without Consult or Follow-up by Center Physician
- ☐ **Polysomnography** and **PAP Titration** if positive for Sleep Apnea, without Consultation or Follow-up by Center Physician

Comments:

Print Provider Name:	Provider Signature:	Date:

Disclosure: Consultations are performed on site by a board certified sleep physician whose practice is located within the Center. Fusion Sleep will perform medically necessary diagnostic testing in the Center based on physician orders. Patients for whom PAP therapy is prescribed have the freedom to choose their DME/homecare providers. The Center will coordinate referrals to either Fusion Sleep Therapy Services LLC or another DME/homecare provider as requested by the patient for the dispensing of therapeutic equipment. Please call Fusion Sleep, Clinical Director at 678.990.3962 for any questions or clarifications. **F060501 – Rev 9**

CONFIDENTIAL PATIENT INFORMATION

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