



Accredited by the  
American Academy of Sleep Medicine

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Home Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Insurance information: \_\_\_\_\_

**Reason for referral: (please circle)**

Snoring	Witnessed apneas	Excessive daytime somnolence
Insomnia	Multiple nocturnal awakenings	Abnormal leg movements during/prior to sleep
Morning Headaches	Bariatric surgery pending	Recent weight gain      Recent weight loss

**Exam findings: (please circle)**

Small oropharynx	Enlarged tongue	Prominent tonsils	Retrognathia
Small/obstructed nasal passages	OTHER: _____		

**Pertinent Coexisting Medical Problems: (please circle)**

Heart Disease	COPD	Hypertension	Diabetes	Pulmonary Hypertension
Neuromuscular Disease	Cardiac or Lung surgery	Obesity	Other _____	

Further Details/ Other: \_\_\_\_\_

Current Medications \_\_\_\_\_

\*\*\*\* To request a consultation with a sleep physician. Please check here  \*\*\*\*

**REQUESTED STUDY:**

NOCTURNAL POLYSOMNOGRAM       CPAP/BIPAP TITRATION

Dr. \_\_\_\_\_ NYS License# \_\_\_\_\_

Address \_\_\_\_\_

PH#: \_\_\_\_\_ FAX#: \_\_\_\_\_

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

**PLEASE FAX WITH PATIENT DEMOGRAPHICS TO (516) 437-7237 or (631) 951-0034**  
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