ENT Direct Referral Form for Sleep Study Fax # (907) 729-1412
Site: _____
Provider Requesting Appt:_____ Phone #:_____
Provider Case Manager:_____ Phone #:_____
Primary Care Provider:_____ Phone #:_____
PCP Case Manager:_____ Phone #:_____

The following is a screening form for adults patients at risk for Obstructive Sleep Apnea. If they have a positive response to 4 or more questions then they meet the criteria for evaluation of sleep apnea by performing a sleep study. The sleep study is an overnight study, which is done at the Alaska Regional Hospital in Anchorage. They will be seen by an ENT doctor after their study to explain the sleep study and discuss the management. Major cause of sleep apnea is being overweight, so please encourage patient to lose weight before they get a sleep study. The ENT evaluation is only to diagnose and explain management of sleep apnea and not initially for a surgical treatment. The mainstay treatment of sleep apnea for adults is CPAP (Continuos Positive Airway Pressure). Patients meeting these criteria can be directly referred to us. We will arrange their sleep study and subsequent appointment.

If you snore excessively and have any of the additional problems listed below, you may have sleep apnea. Please consider discussing a sleep evaluation with your doctor.

- **1. Do you snore loudly? Yes __No __**
- **2. Does your bedroom partner complain about your snoring? Yes __No __**
- **3. Does your snoring wake you up at night? Yes __No __**
- **4. Do you or your bedroom partner notice that you make gasping and choking noises during sleep? Yes __No __**
- **5. Do you have a dry mouth, sore throat or headache in the morning? Yes __No __**
- **6. Do you often fall asleep during the daytime when you want to stay awake? Yes __No_**
- **7. Are you often tired during the day? Yes __No __**
- **8. Do you have high blood pressure? Yes __No__**

Based on the findings from the sleep study and ENT exam, recommendations will be made and communicated to the patient and referring provider. Patients should understand that this appointment is for evaluation only. If surgery is recommended, it will be scheduled at a later date.

Patient Name :_____

Date Of Birth:_____

Social Security #: _____

Guardian's Name :_____

Address:_____

Home Phone #:_____

Work Phone #: _____

Appt Scheduled by:_____

Date & Time_____ **MD:** _____