Delhi Hospital
Sleep Center

501 Broadway St. | Delhi, LA 71232
Sleep Lab Phone: 318-878-6382

REFERRALS OFFICE:
Phone: 318-878-6341 | Fax: 318-878-6141
sleep@delhihospital.com

REFERRAL ORDER FORM

FAX: referral form, insurance cards, relevant clinic notes, lab, x-ray and other test results from the last 12 months to **Sleep Center Referrals Office at 318-878-6141.**

PATIENT INFORMATION

Patient's Name: _____ Date of Birth: _____/_____/_____ Sex: ☐M ☐F

Insurance Carrier: _____ Patient's Preferred Phone #: _____

STOP-BANG QUESTIONNAIRE

STOP

Snore: Do you snore loudly? (Louder than talking or loud enough to be heard through closed doors? ☐YES ☐NO

Tired: Do you often feel tired, fatigued, or sleep during daytime? ☐YES ☐NO

Observed: Has anyone observed you stop breathing during sleep? ☐ YES ☐NO

Pressure: Do you have or being treated for high blood pressure? ☐ YES ☐NO

BANG

BMI: Body mass BMI> 35 kg/m2? ☐YES ☐NO

Age: Age >50 years? ☐YES ☐NO

Neck: Neck circumference >40 cm? ☐YES ☐NO

Gender: Gender male? ☐YES ☐NO

Yes to > 3 questions = high risk of obstructive sleep apnea
Yes to < 3 questions = low risk of obstructive sleep apnea

CO-MORBID CONDITIONS

Congestive Heart Failure ___ EF if known _____
Severe COPD ____
Obesity Hypoventilation Syndrome _____
Venous CO2 ____
PaCO2 _____
EtCO2 _____

CMS REQUIRED ASSOCIATED MEDICAL CONDITIONS TO QUALIFY FOR CPAP

if AHI is 5 to 15 (atleast one of these)

Hypertension _____ Excessive Daytime Sleepiness _____
Stroke_____ Ischemic Heart Disease _____
Insomnia_____ Memory Loss _____ Depression_____

SUSPECTED SLEEP DIAGNOSES

Sleep Disordered Breathing _____
Periodic Leg Movement Disorder _____

TYPE OF SLEEP STUDY REQUESTED

Polysomnography (nPSG) _____
ETCO2 monitoring with nPSG ____
Split Night PSG (PSG +50) _____
PAP titration if indicated by the nPSG _____
MSLT _____
MWT_____

SPECIAL NEEDS OF PATIENT

Vision Impaired _____
Hearing Impaired _____
Wheelchair _____
Guardian Attending _____
Home O2 @ _____ LPM
CPAP @ _____
Bi-level PAP @ _____/_____

REFERRING PHYSICIAN

HOW WOULD YOU PREFER TO BE CONTACTED? ☐ PHONE ☐ FAX ☐ EMAIL

Referring physician/clinician name (print):_____

Office Phone: _____ Office Fax: _____ Email: _____

Physician/clinician signature: _____ Date: _____/_____/_____

Delhi Hospital Sleep Center's Medical Director's Approval Signature/Date: