MMC Sleep Institute 930 Congress Street, Portland, Maine 04101Phone: 207-662-4535 Fax: 207-761-3021

Direct Referral for Sleep Study

Patient Information

Last_____ First_____ MI_____ DOB___/____/_____

Street_____ City_____ State_____ Zip _____

Phone_____ Alternate Phone_____

Email Address_____ Height (in) _____Weight (lb) _____BMI____ (>40, no WPT)

Referral Information

Referring Physician _____ Phone: _____ Fax: _____

Insurance _____ ID: _____PCP_____

Has insurance approval been acquired? □Y □N

Insurance Authorization #:_____ Date Range: _____ Guarantor: _____

Reasons for Testing (check all that apply)

□Apnea □Suspected Parasomnia □Other: _____

□Snoring □Excess. Daytime Somnolence _____

□Insomnia □Seizure Disorder

Is patient currently on CPAP? □Y □N

Has Patient has a prior sleep study elsewhere? □Y □N If yes, please include results if available.

Special Considerations

□Pediatric Patient under age 6

□Needs Caregiver (Walker, W/C, Unable to toilet alone, Dementia, etc.)

□ Needs Interpreter – Language_____

□Other Needs _____

The following documents are **Required** with this referral form:

- Recent Office Notes/H&P Related to Sleep (reflecting medical necessity for sleep study)
- Berlin Questionnaire/Epworth
- Current Medications
- Allergies
- Any Previous Sleep Study Reports

Referrals must be reviewed and approved by our board certified sleep specialist. Once that process is complete, we will contact the patient to schedule the appointment and notify you of the results. The sleep specialist's office may contact your office or the patient should additional information be required.

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BERLIN QUESTIONAIRE

PATIENT NAME: _____ DOB: _____ DATE: _____

Height (in): _____ Weight (lb): _____ Age: _____ Gender: _____

CATEGORY 1:

1. **Do you snore?**
   ☐Yes ☐No ☐Don't Know

2. **How loud is your snoring?**
   _____My snoring is as loud as breathing
   _____My snoring is as loud as talking
   _____My snoring is louder than talking
   _____My snoring is very loud

3. **How frequently do you snore?**
   _____Almost every day
   _____3 - 4 times per week
   _____1 - 2 times per week
   _____1 – 2 times per month
   _____Never or almost never

4. **Does your snoring bother other People?** ☐Yes ☐No ☐Don't know

5. **How often have your breathing pauses been noticed?**
   _____Almost every day
   _____3 – 4 times per week
   _____1 – 2 times per week
   _____1 – 2 times per month
   _____Never or almost never

CATEGORY 2:

6. **Are you tired after sleeping?**
   ____Almost every day
   _____3 – 4 times per week
   _____1 – 2 times per week
   _____1 – 2 times per month
   _____Never or almost never

7. **Are you tired during wake time?**
   _____Almost every day
   _____3 – 4 times per week
   _____1 – 2 times per week
   _____1 – 2 times per month
   _____Never or almost never

8. **How often do you nod off or fall asleep while driving?**
   _____Almost every day
   _____3 – 4 times per week
   _____1 – 2 times per week
   _____1 – 2 times per month
   _____Never or almost never

CATEGORY 3:

9. **Do you have high blood pressure?**
   ☐Yes ☐No ☐Don't know