The Barbara Bush Children's Hospital
At Maine Medical Center

Maine Medical Center
MaineHealth
centered around you

Maine Sleep Institute

Phone: 662-4535 *Fax 761-3021*

Referral for Sleep Study

Patient Information

Last_____ First_____ MI___ DOB__/__/___

Street_____ City_____ State____ Zip _____

Phone_____ Alternate Phone_____

Insurance _____ ID: _____PCP_____

Referral Information

Referring Physician _____ Phone:_____ Fax:_____

Has insurance approval been acquired? ❑Y ❑N Procedure Code:_____ Date Range: _____

Reasons for Testing (check all that apply)

❑Apnea ❑Suspected Parasomnia ❑Other: _____
❑Snoring ❑Excess. Daytime Somnolence _____
❑Insomnia ❑Seizure Disorder

Is patient currently on C-Pap? ❑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 Interpreter ❑Other Needs _____
❑Needs Caregiver Language_____ _____

Please include the following with your referral

■Office Notes Related to Sleep ■ Allergies ■Current Medications ■Berlin Questionnaire/Epworth

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.

Office Use Only:

Study to be read by: G. Bokinsky L. Kaminow C. Murry S. Gorman T. Mellow

Type of Test Requested

❑ Diagnostic PSG Only
Pediatric Pts: ❑ Monitor Legs ❑$ETCO_2$
❑Split Night PSG (Dx + Tx PSG if criteria met)
❑AHI>20 ❑AHI>30
❑Cpap/BiPap/ O2 Titration PSG
(Requires prior Dx of OSA by PSG)

❑ASV Titration
❑Split Night PSG with **MSLT** if AHI<5
❑MWT
❑CPAP Mask fitting Acclimation clinic
❑Home Sleep Study
❑Parasomnia Montage ❑Seizure Montage

Sleep Specialist Approval: _____,MD/DO Date:_____

Comments:_____

Revised: 2/27/2017

PATIENT:_____ DOB: _____ DATE:_____

Height (m) _____ Weight (kg) _____ BMI_____

BERLIN QUESTIONAIRE

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

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 waketime?

_____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