Stellar
SLEEP DIAGNOSTICS

# Sleep Disorders Laboratory Referral Sheet

**701 E. Tudor Rd., Suite 140**
**Anchorage, AK 99503**
**Office: (907) 646-1009 Fax: (907) 646-1013**

Date:_____

_____ _____ ○ M ○ F
Patient Name Date of Birth

_____ _____ _____ _____
Height Weight Home Phone Alternate Phone

## SYMPTOMS

- ○ Snoring
- ○ Excessive Daytime Sleepiness
- ○ Witnessed Apneas
- ○ Waking With Gasp/choking
- ○ Difficulty Falling Asleep or Staying Asleep
- ○ Morning Headache
- ○ Teeth Grinding
- ○ Waking Feeling Tired
- ○ Restless Sensation In Arms or Legs
- ○ Kicking Movements While Asleep
- ○ Sleep Paralysis
- ○ Depression
- ○ Impaired Daytime Concentration/Memory
- ○ GERD

## MEDICAL HISTORY

- ○ Hypertension
- ○ History of Stroke
- ○ Impaired Cognition
- ○ Diabetes
- ○ Fibromyalgia
- ○ CHF/CAD (Ischemic Heart Disease)
- ○ Mood Disorders
- ○ Asthma / COPD
- ○ Seizures
- ○ Cardiac Arrhythmias
- ○ Chronic Pain
- ○ Insomnia

## PROCEDURE REQUESTED

- ○ Sleep Consultation with a sleep physician.
- ○ Diagnostic Sleep Study (will automatically split if meets criteria).
- ○ CPAP Titration/Re-Titration
- ○ Multiple Sleep Latency Test

**COMMENTS:**_____

_____ _____ _____
Physician Signature Physician Printed Name NPI#

_____ _____
Phone Number Fax

Fax this form, with chart notes to:
**FAX (907) 646-1013**