Coordinated Health
SLEEP DISORDER CENTER

Outpatient Department of CH Hospital of Allentown, LLC
1503 N. Cedar Crest Blvd | Allentown, PA 18104
P: 610-861-8080 Ext: 28041 | F: 610-849-1028

COORDINATED HEALTH SLEEP DISORDER CENTER REFERRAL FORM
2300 HIGHLAND AVE. BETHLEHEM PA 18020

Please fax completed form with office notes to 610-849-1028

PATIENT INFORMATION

Patient's Full Name: _____

Gender:_____ Date of Birth: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Please circle the preferred contact number above. Okay to leave message? ◯ Yes ◯ No

HISTORY AND PHYSICAL INFORMATION

Height (in): _____ Weight (lbs): _____ Neck Size (in): _____ Resting BP: _____

Known Allergies: _____

Medications: _____

****Please include medications you are prescribing for your patient to take specifically for sleep or for this study in the medication list.

***Minimum of 2 Symptoms with Comorbidities must be checked.**

DESCRIPTION OF SYMPTOMS

◯ Excessive daytime sleepiness
◯ Snoring
◯ Witnessed apneas
◯ Non-Restorative sleep
◯ RLS
◯ Parasomnias OTHER _____

MEDICAL COMORBIDITIES OR SUSPECTED SLEEP COMORBIDITIES

◯ Hypertension ◯ Diabetes ◯ COPD/Asthma
◯ Seizures ◯ Heart Disease ◯ Stroke
◯ Suspected Central Apnea ◯ Suspected Parasomnias ◯ Suspected Narcolepsy
◯ Suspected PLMS or RLS ◯ Suspected Circadian Rhythm Disorder

Mental Status: ◯ Normal ◯ Abnormal
Ambulatory Status: ◯ Normal ◯ Abnormal
List any limitations: _____

PROVIDER ORDER

◯ Diagnostic Polysomnogram, 95810
◯ CPAP Titration, 95811
◯ Split Study, 95811 (patient must meet Center Protocol)
◯ Maintenance of Wakefulness Test (MWT) 95805
◯ Multiple Sleep Latency Test (MSLT) 95805
◯ Other, please specify: _____

Please check circle that applies:
◯ Consultation and Treatment provided by Sleep Center Physician (Most Patients)
◯ Direct Referral – Testing WITHOUT Consultation or Follow-Up with Sleep Center Physician. Select this only if a qualified sleep physician outside of the Coordinated Health Sleep Disorder Center will interpret testing results.

PROVIDER INFORMATION

Office Contact Name: _____ Phone: _____ Fax: _____
Provider Name: _____ Provider Signature: _____

Physician Signature: _____ Date: _____