



West Region Sleep Center

15805 Puritas Avenue, Cleveland, Ohio 44135
216-267-5933

Physician Referral Form

Patient Name _____ Sex: Male Female

Date of birth: _____ Primary Care Physician _____

Address: _____

Home phone: _____ Cell/Work phone: _____

Social Security Number: _____ Height: _____ Weight: _____

Health Insurance

Carrier name: _____ Phone number: _____

Group number: _____

Subscriber number: _____

Ordering Physician (please print or stamp name here)

Phone Number _____

Office Address _____

Fax Number _____

Does Patient have cardiac problems? ___ NO ___ YES

Describe _____

Does Patient have lung problems? ___ NO ___ YES

Describe _____

is Patient on O2? ___ NO ___ YES

Level _____ Start Study on O2? _____

is Patient on CPAP? ___ NO ___ YES

Level _____ Start Study on CPAP? _____

CLINICAL INDICATIONS

PRELIMINARY DIAGNOSIS

- Loud snoring
- Bedpartner observes apnea
- Gasping episode at night
- Excessive sleepiness
- Morning headaches
- Trouble concentrating
- Loss of energy
- Overweight / obesity
- Other _____

- 327.23 Obstructive sleep apnea
- 780.53 Hypersomnia with sleep apnea
- 780.56 Sleep stage dysfunction
- 780.57 Unidentified sleep apnea
- _____

TYPE OF PROCEDURE NEEDED

- 95810 Polysomnogram
- 95811 CPAP Titration
- 95805 MSLT--Multiple Sleep Latency Test
- 95805 MWT--Maintenance Wakeful Test
- _____ Other _____

Interpreting Physician

Physician Signature _____

Babu M. Eapen, M.D.

Gregory G. Hickey, D.O.

Date _____

Robert B. Gerber, M.D.

Linas F. Vaitkus, M.D.

Follow up with sleep doctor? Yes No

Basma Ricaurte, M.D.

Paul C. Venizelos, M.D.

To Schedule

Please do not give this form to patient. Please fax completed form, recent H&P or last patient visit notes and copy of insurance card(s) to the Sleep Center at 216-267-5133. For any additional information, please call our office at 216-267-5933.

Paul C. Venizelos, MD, FCCP, FACP

Medical Director