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Alexandria - Arlington - Chantilly - Dumfries - Germantown - Lansdowne - Manassas - N. Bethesda - Woodbridge

PATIENT

Last Name: _____ First: _____ DOB: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Primary Phone: _____ Alternate Phone: _____ Email: _____
 Special Assistance Needed? Yes No Gender: M F

REFERRING PHYSICIAN

Last Name: _____ First: _____ MD PA NP DDS NPI: _____
 Practice Name: _____
 Phone: _____ Fax: _____ Address: _____

WHY REFERRING - INDICATIONS FOR CONSULTATION/SLEEP STUDY

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Narcolepsy | <input type="checkbox"/> Daytime Irritability | <input type="checkbox"/> DOT Physical |
| <input type="checkbox"/> Hypersomnia | <input type="checkbox"/> Hyperactivity/Inattention | <input type="checkbox"/> Gasping/Choking During Sleep | <input type="checkbox"/> Bariatric Surgery |
| <input type="checkbox"/> Nocturnal Enuresis | <input type="checkbox"/> Excessive Daytime Sleepiness | <input type="checkbox"/> Bruxism | <input type="checkbox"/> Other : _____ |
| <input type="checkbox"/> Waking Feeling Tired | <input type="checkbox"/> AM Headaches | <input type="checkbox"/> Mouth Breathing | |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> RLS/PLMD | <input type="checkbox"/> Circadian Rhythm D/O | |
| <input type="checkbox"/> Observed Apnea | <input type="checkbox"/> Frequent Awakening | <input type="checkbox"/> Insomnia | |

MEDICAL HISTORY

- | | | | |
|---|---------------------------------------|---|--|
| <input type="checkbox"/> Prior History of OSA | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Cardiac Arrhythmias | <input type="checkbox"/> S/P Adenoidectomy/Tonsillectomy |
| <input type="checkbox"/> HX Stroke | <input type="checkbox"/> Obesity | <input type="checkbox"/> Other Airway Surgery | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> GERD | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Chronic Pain |
| <input type="checkbox"/> Autism | <input type="checkbox"/> CHF/CAD | <input type="checkbox"/> Impaired Cognition | <input type="checkbox"/> Depression/Anxiety |
| <input type="checkbox"/> Asthma/COPD | <input type="checkbox"/> Seizures | | |

SELECT SERVICE OPTION

- | | | |
|---|---|---|
| <input type="checkbox"/> Sleep Consultation with Sleep Medicine Physician | <input type="checkbox"/> ASV Titration Study | <input type="checkbox"/> Multiple Sleep Latency Test (MSLT) |
| <input type="checkbox"/> Evaluate & Treat | <input type="checkbox"/> Home Sleep Study, Unattended Diagnostic | <input type="checkbox"/> Auto CPAP Set-up |
| <input type="checkbox"/> Polysomnogram (PSG) Diagnostic Sleep Study | <input type="checkbox"/> Home Sleep Study & Treat (If positive for OSA) | <input type="checkbox"/> CPAP Set-up |
| <input type="checkbox"/> Split-Night Study (Adherence to AASM & Insurance Guidelines) | <input type="checkbox"/> Oral Appliance Therapy | <input type="checkbox"/> BIPAP Set-up |
| <input type="checkbox"/> CPAP Titration Study | <input type="checkbox"/> Oral Appliance Follow-up Sleep Study | <input type="checkbox"/> ASV Set-up |
| <input type="checkbox"/> BIPAP Titration Study | <input type="checkbox"/> Maintenance of Wakefulness Test | <input type="checkbox"/> Supplies |

PLEASE FAX OR EMAIL THIS COMPLETED FORM, PATIENT DEMOGRAPHICS AND DOCTOR'S NOTES TO (703) 729-3422 or (571) 291-9985 or INFO@COMPREHENSIVESLEEP CARE.COM

Physician Signature: _____ Printed Name: _____ Date: ___ / ___ / ___

REFERRAL FOR ADULT & PEDIATRIC CONSULTATIONS & SLEEP STUDIES

9 CONVENIENT LOCATIONS

ALEXANDRIA/SPRINGFIELD: (January 2020)
5901 Kingstown Village Pkwy., #101, Alexandria, VA 22315

ARLINGTON:
200 N. Glebe Road, #316, Arlington, VA 22203

CHANTILLY:
4080 Lafayette Center Drive, #170C, Chantilly, VA 20151

DUMFRIES:
3687 Fettle Park Drive, Dumfries, VA 22025

GERMANTOWN:
12321 Middlebrook Road, Germantown, MD 20874

LANSDOWNE:
19441 Golf Vista Plaza, #230, Lansdowne, VA 20176

MANASSAS:
9420 Forestwood Lane, #202, Manassas, VA 20110

N. BETHESDA:
6000 Executive Blvd, #604, Bethesda, MD 20852

WOODBIDGE:
4897 Prince William Pkwy., #102, Woodbridge, VA 22192

STOP-BANG SLEEP SCREEN

STOP

- S - Do you **SNORE** loudly (louder than talking or loud enough to be heard through closed doors)? YES NO
- T - Do you often feel **TIRED**, fatigued, or sleepy during the day? YES NO
- O - Has anyone **OBSERVED** you stop breathing during your sleep? YES NO
- P - Do you have or are you being treated for high blood **PRESSURE**? YES NO

BANG

- B - Is your **BODY MASS INDEX (BMI)** more than 28? YES NO
- A - **AGE** - Are you over 50 years old? YES NO
- N - Are you a man with a **NECK** circumference greater than 17 inches or a woman with a **NECK** circumference greater than 16 inches? YES NO
- G - **GENDER** - Are you a male? YES NO

TOTAL SCORE

High risk of OSA: Yes, 5 - 8

Intermediate risk of OSA: Yes, 3 - 4

Low risk of OSA: Yes, 0 - 2

OSA - Low Risk: Yes to 0 - 2 questions

OSA - Intermediate Risk: Yes to 3 - 4 questions

OSA - High Risk: Yes to 5 - 8 questions

or Yes to 2 or more of 4 STOP questions + male gender

or Yes to 2 or more of 4 STOP questions + BMI >35kg/m²

or Yes to 2 or more of 4 STOP questions + neck circumference 17 inches / 43 cm in male or 16 inches / 41 cm in female