

Our Providers: Charu Sabharwal, MD • K. Danielle Sullivan, DO • Sean Rotolo, MD • Shahriar Shahzeidi, MD • Sharmili Mathur, D.O.

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

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:

5901 Kingstowne Village Pkwy., #101
Alexandria, VA 22315

DUMFRIES:

3687 Fettle Park Drive
Dumfries, VA 22025

MANASSAS:

9420 Forestwood Lane, #202
Manassas, VA 20110

ARLINGTON:

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

GERMANTOWN:

12321 Middlebrook Road
Germantown, MD 20874

N. BETHESDA:

6000 Executive Blvd, #604
Bethesda, MD 20852

CHANTILLY:

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

LANSLOWNE:

19441 Golf Vista Plaza, #230
Lansdowne, VA 20176

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