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Alexandria - Arlington - Bethesda - Chantilly - Dumfries - Fredericksburg - Germantown - Lansdowne - Manassas - 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"/> 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	<input type="checkbox"/> eXcite OSA
		<input type="checkbox"/> Insomnia Home Test

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

10 CONVENIENT LOCATIONS

ALEXANDRIA

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

ARLINGTON

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

BETHESDA

6000 Executive Blvd, #604
Bethesda, MD 20852

CHANTILLY

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

DUMFRIES

3687 Fettle Park Drive
Dumfries, VA 22025

FREDERICKSBURG

605 Emancipation Hwy, #2B
Fredericksburg, VA 22401

GERMANTOWN

12850 Middlebrook Road, #250
Germantown, MD 20874

LANSDOWNE

19441 Golf Vista Plaza, #230
Lansdowne, VA 20176

MANASSAS

9420 Forestwood Lane, #202
Manassas, VA 20110

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