FIRST COAST CARDIOVASCULAR INSTITUTE

First Coast Cardiovascular Institute
Sleep Disorders Center
Phone: 904.493.3333
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Direct Referral for Sleep Study

Please complete this form and submit a current history and physical for the patient. After review of the information and approval of the requested sleep study by our sleep medicine physician, the patient will be contacted to schedule a sleep study.

Patient Personal Information:

Name: _____ Home Phone: _____

DOB: _____ Cell Phone: _____ Work phone: _____

Demographics: Gender: ☐ M ☐ F Age: _____ Height: _____ Weight: _____

History of Sleep Problem:

☐ Daytime Sleepiness	☐ Shift Work	☐ Morning Headaches	☐ Snoring
☐ Cataplexy	☐ Nocturia	☐ Witnessed Apneas	☐ Sleep Paralysis
☐ Claustrophobia	☐ Insomnia	☐ Frequent Awakenings	☐ Sleepwalking/talking
☐ Fatigue	☐ Restless Legs	☐ Seizures	☐ Other
☐ Home O2 _____ L	☐ CPAP/ BIPAP: _____ cm H2O		☐Oral Appliance

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Comorbidities:

☐ MI/CAD	☐ TIA/CVA	☐ CHF	☐ Diabetes	☐ Hyperlipidemia
☐ Neuromuscular Dis	☐ Hypertension	☐ Obesity	☐ Depression	☐ Anxiety
☐ Substance Abuse Cardiac				

Consultation Request: ☐ Routine ☐ Re-Assessment

Urgent:

☐ Safety Critical Occupation ☐ Severe Daytime Sleepiness
☐ Oximetry with severe sleep apnea ☐ Motor Vehicle Accident
☐ Driver's License Suspension ☐ Recent MI or CVA
☐ Pre-Operative assessment OR: _____ Date_____

Special Needs:

☐ Oxygen ☐ Assistance Moving ☐ Wheelchair ☐ Difficulty hearing ☐ Communicating ☐ Other

Ordering Physician: _____ Signature: _____ Date: _____
