1515 Delhi Street, Suite 100
Dubuque, IA 52001
563-557-9111

SLEEP MEDICINE REFERRAL

Is the patient currently using CPAP? Yes No

Please choose the most appropriate sleep concern for your patient:

_____ SLEEP DISORDERED BREATHING
This may include: Obstructive Sleep Apnea
Central Sleep Apnea
Obesity Hypoventilation Syndrome
Snoring
CPAP Intolerance

_____ HYPERSOMNIA
This may include: Sleep disordered breathing
Narcolepsy
Idiopathic hypersomnia
Other sleep disorders

_____ INSOMNIA (including Cognitive Behavioral Therapy for Insomnia)
This may include: Insomnia
Circadian rhythm disorders
Sleep disordered breathing
Other sleep disorders

_____ CIRCADIAN RHYTHM DISORDERS
This may include: Shift work disorder
Jet Lag therapy
Delayed and Advanced sleep phase disorder
Irregular sleep-wake rhythm
Non-entrained sleep-wake disorder

_____ PARASOMNIAS
This may include: Sleep Walking
Sleep Terrors
Nightmares
REM – Behavior Disorder
Other abnormal events occurring during sleep

_____ RESTLESS LEG SYNDROME
This may include: RLS
Periodic limb movement disorder

_____ OTHER: Please describe: _____

Patient's name: _____ Date of birth: _____

Patient's phone number: _____

Referring provider: _____ Provider fax: _____

Appointment already made? Yes or No: If "NO", we will call patient to schedule

Please forward any pertinent records, including any laboratory and radiology studies. A recent list of medications would be appreciated.