Pulmonary and Sleep Center of New England

Mohammad Khamiees, MD, FCCP, FACP
3353 Mendon Rd Ste 3
Cumberland, RI 02864
Phone: (401) 405-0899 Fax: (401) 405-0890

SLEEP STUDY & PULMONARY FUNCTION TEST REFERRAL FORM

Patient Name: _____ DOB: _____

Sex: □ Male □ Female Height: _____ Weight: _____

Address: _____
City State Zip

Email: _____

Phone: _____
Home Cell Work

Emergency Contact: _____ Phone: _____

Insurance Carrier: _____ ID# _____
(Copy of insurance card is required for Prior Authorization) **Prior Authorization Required: Yes No**

SLEEP STUDY PROCEDURE ORDERS

□ Please schedule this patient for sleep evaluation consultation **and** sleep testing

□ HOME STUDY □ PSG

□ Please automatically schedule my patient for a subsequent titration study if the patient is positive for OSA.

□ CPAP □ Bi-Pap □ Split night □ MSLT (Multiple Sleep Latency Test)

Is patient on oxygen? □ No □ Yes _____ Liter(s)

□ Please schedule this patient to see Dr. Khamiees for sleep study results

CLINICAL SYMPTOMS/PRESENTATION

- □ Disruptive snoring
- □ Excessive daytime sleepiness
- □ Non-restorative sleep
- □ Witnessed apneas/gasping during sleep
- □ Frequent awakenings
- □ Morning headaches
- □ Persistent symptoms > 4 weeks

COMORBID CONDITIONS

- □ Moderate to severe pulmonary disease
- □ Congestive heart failure
- □ Pulmonary hypertension
- □ Recent stroke or MI
- □ Neuromuscular/neurodegenerative disorder
- □ Obesity hypoventilation syndrome
- □ Ischemic heart disease

****Please fax any relevant clinical information/medical records along with referral form****

PULMONARY FUNCTION TEST PROCEDURE ORDERS

□ Complete pulmonary function test w/DLCO Diagnosis: _____

□ Please schedule patient to see Dr. Khamiees for results and/or treatment, if needed.

ORDERING PHYSICIAN

Ordering provider (print name): _____ Phone: _____

Signature: _____ Fax: _____

Primary Care Physician: _____ Date: _____

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