**Pulmonary and Sleep Center of New England**

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**SLEEP STUDY & PULMONARY FUNCTION TEST REFERRAL FORM**

Date Ordered: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bed#: \_\_\_\_\_\_\_\_\_ Date of Study: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_

Sex: 🞎Male 🞎Female Height: \_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City State Zip

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 physician (print name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_