

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

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: _____ Fax: _____

Primary Care Physician: _____ Date: _____