TeleSleep Clinic Telehealth sleep care
Phone / Text: (701) 335-6357 | Fax: (701) 999-1099 | Email: info@telesleepclinic.com | Website: telesleepclinic.com
Service area: ND, SD, MN, IA, WI | Practice address: 3284 51st St S Unit 3, Fargo, ND 58104

Sleep Medicine Referral Form

Arveity Setty, MD, FAASM, FAAP — Triple board-certified in Pediatrics, Sleep Medicine, and Obesity Medicine (DABOM) — Serving patients ages 2 and up

FAX COMPLETED FORM TO
(701) 999-1099
Goes directly to our EMR

For referring provider offices only: Please print, complete all sections that apply, and fax to **(701) 999-1099**. Please attach a copy of the patient's insurance card (front and back) and relevant clinical notes. We will contact the patient to schedule. Insurance patients require a consultation before a home sleep study. In-network with BCBS PPO and accepting Medicare.

1 — REFERRING PROVIDER

REFERRING PROVIDER NAME (PRINT) _____ CREDENTIALS / SPECIALTY _____

PRACTICE / CLINIC NAME _____ NPI (IF KNOWN) _____

OFFICE PHONE _____ OFFICE FAX _____ OFFICE CONTACT / EMAIL _____

☐ Send consultation findings / study results back to our office ☐ Co-manage care ☐ Evaluate and treat

2 — PATIENT INFORMATION

PATIENT FULL LEGAL NAME _____ DATE OF BIRTH _____ SEX _____

PATIENT PHONE (MOBILE PREFERRED) _____ PATIENT EMAIL _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

PARENT / GUARDIAN NAME (IF PATIENT IS A MINOR) _____ GUARDIAN PHONE _____

HEIGHT _____ WEIGHT _____ BMI (IF KNOWN) _____ NECK CIRCUMFERENCE (IF KNOWN) _____

3 — INSURANCE INFORMATION

Please also fax a copy of the insurance card, front and back.

☐ BCBS PPO ☐ Medicare ☐ Other insurance — plan name: _____ ☐ Self-pay

INSURANCE COMPANY / PLAN NAME (WRITE IN IF "OTHER INSURANCE") _____ MEMBER ID _____

GROUP NUMBER _____ POLICY HOLDER NAME & DOB (IF DIFFERENT) _____

4 — REASON FOR REFERRAL & CLINICAL SYMPTOMS

☐ Suspected sleep apnea ☐ Snoring ☐ Excessive daytime sleepiness ☐ Insomnia

☐ Restless legs / periodic limb movements ☐ Pediatric sleep concern ☐ CPAP follow-up / compliance

☐ Home sleep study requested ☐ Consultation requested ☐ Other

☐ Loud snoring ☐ Witnessed apneas / gasping ☐ Hypertension ☐ Diabetes ☐ Heart disease / AFib
☐ Morning headaches ☐ Unrefreshing sleep ☐ Stroke history ☐ Obesity ☐ Depression / anxiety
☐ Frequent night waking ☐ Nocturia ☐ Prior sleep study ☐ Currently on CPAP

ADDITIONAL CLINICAL NOTES / RELEVANT HISTORY, MEDICATIONS, OR CONCERNS

_____

Patient name: _____ DOB: _____ Complete for adults. For children, complete page 3 instead (STOP-BANG and ESS may still be completed for older teens if relevant).

5 — STOP-BANG QUESTIONNAIRE (ADULTS)

Circle Yes or No for each item. Score 1 point for each Yes.

#	QUESTION	ANSWER
S	**Snoring:** Do you snore loudly (louder than talking, or loud enough to be heard through closed doors)?	Yes / No
T	**Tired:** Do you often feel tired, fatigued, or sleepy during daytime?	Yes / No
O	**Observed:** Has anyone observed you stop breathing during your sleep?	Yes / No
P	**Pressure:** Do you have, or are you being treated for, high blood pressure?	Yes / No
B	**BMI:** Is your body mass index (BMI) more than 35 kg/m^2?	Yes / No
A	**Age:** Are you over 50 years old?	Yes / No
N	**Neck:** Is your neck circumference greater than 16 inches (40 cm)?	Yes / No
G	**Gender:** Are you male?	Yes / No

STOP-BANG total score: _____ / 8 | 0–2 = low risk • 3–4 = intermediate risk • 5–8 = high risk for obstructive sleep apnea. This is a screening tool only and does not by itself diagnose sleep apnea.

6 — EPWORTH SLEEPINESS SCALE (ESS)

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? Rate each situation from **0 to 3** based on your usual way of life in recent times, even if you have not done some of these things recently.

0 = would never doze | **1** = slight chance of dozing | **2** = moderate chance of dozing | **3** = high chance of dozing

SITUATION	SCORE (0–3)
1. Sitting and reading	
2. Watching TV	
3. Sitting inactive in a public place (for example, a theater or a meeting)	
4. As a passenger in a car for an hour without a break	
5. Lying down to rest in the afternoon when circumstances permit	
6. Sitting and talking to someone	
7. Sitting quietly after a lunch without alcohol	
8. In a car, while stopped for a few minutes in traffic	

ESS total score: _____ / 24 | 0–10 = normal daytime sleepiness • 11–24 = excessive daytime sleepiness. This is a screening tool only.

Additional adult history (check all that apply)

☐ Difficulty falling asleep ☐ Difficulty staying asleep ☐ Early morning waking

☐ Restless legs / urge to move legs at night ☐ Sleepwalking / sleep talking ☐ Nightmares

☐ Shift work / irregular schedule ☐ Falls asleep while driving ☐ Uses sleep aids / sedatives

CURRENT SLEEP MEDICATIONS / CPAP SETTINGS / OTHER NOTES

Patient name: _____ DOB: _____ Complete this page only if the patient is under 18.

7 — PEDIATRIC SLEEP QUESTIONNAIRE (CHILDREN ONLY)

Completed by: ☐ Parent / Guardian ☐ Referring office ☐ Other: _____

CHILD'S USUAL BEDTIME _____

USUAL WAKE TIME _____

SCHOOL / GRADE _____

While sleeping, does your child… (check all that apply)

- ☐ Snore more than half the time
- ☐ Always snore
- ☐ Snore loudly
- ☐ Have heavy or loud breathing
- ☐ Have trouble breathing, or struggle to breathe
- ☐ Stop breathing during the night (witnessed apnea)
- ☐ Breathe through the mouth during the day
- ☐ Have a dry mouth on waking in the morning
- ☐ Occasionally wet the bed
- ☐ Sleep restlessly / toss and turn
- ☐ Sleepwalk, sleep-talk, or have night terrors
- ☐ Grind teeth during sleep

During the day / at school, does your child… (check all that apply)

- ☐ Wake up unrefreshed in the morning
- ☐ Have a problem with sleepiness during the day
- ☐ Fall asleep at school or during activities
- ☐ Have difficulty waking in the morning
- ☐ Teacher or caregiver comments they seem sleepy
- ☐ Show inattention, hyperactivity, or behavior concerns
- ☐ Have declining school performance
- ☐ Have morning headaches

TONSILS / ADENOIDS — ENLARGED, REMOVED, OR CONCERNS? _____

ALLERGIES / ASTHMA? _____

OTHER PEDIATRIC CONCERNS (GROWTH, DEVELOPMENT, PRIOR SLEEP STUDY, CURRENT TREATMENTS)

_____

Pediatric home sleep study is designed for children up to age 12. Ages 13–17 may use the adult home sleep study if finger size allows the sensor to fit; otherwise the pediatric study is used. Final device selection is made by Dr. Setty per patient.

8 — URGENCY, ATTACHMENTS & SIGNATURE

IS THERE ANYTHING MORE WE SHOULD KNOW ABOUT THIS PATIENT?

_____

Please attach clinic notes, if appropriate, and a copy of the patient's insurance card (front and back).

Urgency: ☐ Routine ☐ Priority — please contact patient soon ☐ Urgent — safety concern (for example, drowsy driving)

Attached / faxed with this form: ☐ Insurance card (front & back) ☐ Clinical notes ☐ Medication list ☐ Prior sleep study ☐ Other records

REFERRING PROVIDER SIGNATURE _____

DATE _____

PRINT NAME (IF DIFFERENT FROM SECTION 1) _____

BEST CALLBACK NUMBER FOR QUESTIONS _____

What happens next: Fax this completed form to **(701) 999-1099**. TeleSleep Clinic will contact the patient to schedule, verify insurance where applicable, and send findings back to your office if requested above. Questions? Text or call (701) 335-6357 or email info@telesleepclinic.com.

Confidentiality notice: This fax is intended only for TeleSleep Clinic and contains confidential health information. If you received this fax in error, please notify the sender immediately and destroy all copies. Do not email this completed form — please fax it so it goes directly to the clinic's EMR.