Sandhills NEUROLOGISTS
NEUROLOGY • SLEEP • BALANCE

REFERRAL FORM

OFFICE LOCATIONS

251 Keisler Drive Suite 100
Cary, NC 27518

101 Dennis Drive
Sanford, NC 27330

295 Olmsted Boulevard
Mellon Bldg, Suite12
Pinehurst, NC 28374

Please include the following:
- *Patient demographics sheet*
- *Patient insurance information*
- *Most recent office note and/or medical history*

NEUROLOGY REFERRAL

☐ **Neurology Consultation**
Evaluation, treatment and management of care
- ☐ Henry Tellez, MD
- ☐ Giridhar Chintalapudi, MD, FAASM

☐ **dTMS Consultation (No Charge)**

Diagnostic Testing ONLY
- ☐ Nerve Conduction/EMG
- ☐ EEG
- ☐ Video EEG Monitoring (Including Pediatrics)
- ☐ Balance & Dizziness Testing (VNG-Videonystamography)
- ☐ MRI (Cary)

Reason for Referral
- ☐ Arm/Neck Pain
- ☐ Memory Loss
- ☐ Dizziness/Vertigo
- ☐ Headaches
- ☐ TIA/Stroke
- ☐ Carpal Tunnel
- ☐ Other: _____

SLEEP MEDICINE REFERRAL

☐ **Sleep Consultation**
Evaluation, treatment and management of care

☐ **Split-Night Sleep Study** w/Post-Sleep Consultation*
Review of sleep study results, treatment and management of care

Diagnostic Testing ONLY*
- ☐ Diagnostic Sleep Study
- ☐ Titration Sleep Study
- ☐ Maintenance of Wakefulness Test
- ☐ Split-Night Sleep Study
- ☐ Home Sleep Study
- ☐ Multiple Sleep Latency Test

**Must fill out back side of this form and fax separately.*

PAP Therapy
- ☐ CPAP Setup _____cmH2O
- ☐ CPAP Mask & Supplies

Reason for Referral
- ☐ Excessive Daytime Sleepiness
- ☐ Witnessed Apnea
- ☐ Restless Legs
- ☐ Snoring
- ☐ Daytime Fatigue
- ☐ Narcolepsy
- ☐ Insomnia
- ☐ Other: _____

Patient Information

Patient Name: _____

Date of Birth: _____

Phone: _____

Cell: _____

Referring Physician Information

Practice Name: _____

Address: _____

Phone: _____ Fax: _____

Physician's Name: _____

Physician's Signature: _____

Sandhills NEUROLOGISTS
NEUROLOGY • SLEEP • BALANCE

DIRECT SLEEP REFERRAL

OFFICE LOCATIONS

251 Keisler Drive Suite 100
Cary, NC 27518

101 Dennis Drive
Sanford, NC 27330

295 Olmsted Boulevard
Mellon Bldg, Suite12
Pinehurst, NC 28374

Please complete the following if you are referring a patient for a SLEEP STUDY without seeing our sleep physician first.

Some insurance companies now require prior authorization for an overnight attended sleep study. As a courtesy, Sandhills Neurologists, PA, can obtain this authorization for you, but will require the following information.

(If you prefer, you can refer your patient to see our sleep physician prior to any sleep study performed. Our physician will obtain all the necessary information needed for insurance prior authorizations and you will not need to fill out this form).

Please check all that apply:

- ☐ Disruptive Snoring
- ☐ Engagement in Safety-Critical Occupation
- ☐ Epworth Sleepiness Scale > 10 (Please indicate score_____.)
- ☐ Witnessed Apneas, Choking or Gasping During Sleep
- ☐ Failed Lifestyle Modifications for Symptom Relief. Examples include:
  - O Good Sleep Hygiene
  - O Reduction of Alcohol Consumption, Especially Before Bedtime
  - O Sleeping in Lateral Body Position
  - O Weight Loss

A more in-depth sleep study may be necessary if one or more of the following exists.
Please check all that apply:

- ☐ Chronic Pulmonary Disease
- ☐ Neuromuscular Disease / Neurodegenerative Disorder
- ☐ Significant Cardiac Disease
- ☐ Body Mass Index (BMI) >= 50
- ☐ Obesity Hypoventilation Syndrome (OHS)
- ☐ One (1) or more of the following complex sleep disorders. Check all that apply:
  - ___Periodic Limb Movement Disorder (PLMD)
  - ___Parasomnia w/Disruptive Sleep Behavior Suspicious of REM Behavior Disorder (RBD)
  - ___Narcolepsy
  - ___History of Central Sleep Apnea
- ☐ Results of previous Home Sleep Test (HST) were indeterminate or technically inadequate.
- ☐ Patient lacks mobility, dexterity or is cognitively impaired; therefore cannot use the HST equipment safely at home.
- ☐ Due to the following reasons: _____

Patient Information

Patient Name: _____

Date of Birth: _____

Phone: _____

Cell: _____

Referring Physician Information

Practice Name: _____

Address: _____

Phone: _____ Fax: _____

Physician's Name: _____

Physician's Signature: _____