New Patient

UCI Sleep Medicine

UCI Health

UCI Health Newport – Birch Street
20350 SW Birch St.
Newport Beach, CA 92660

714-509-2230 (phone)
1-877-829-7891 (FAX)

Patient Information (Please Print)

Patient Name	Home Phone	DOB
Street Address	City/State/Zip	
Work/Cell phone	M/F	Email
Insurance	ID #	Subscriber #

Primary Care Physician

Primary Care Physician	Phone	Fax
Office Address	City/State/Zip	
Email		

Services Requested (Check one box only)

Sleep Testing Only

☐ No follow up services will be provided. Includes sleep test, initiation of CPAP during test if indicated.

Sleep Testing & Consultation

☐ Polysomnography or home sleep test will be performed only if clinically indicated. Sleep testing may precede consulatation if sufficient documentation available from referring provider.

Consultation

☐ Clinic consult to evaluate patient and give opinion/advice. Sleep testing may be ordered after consulatiton if clinically indicated.

Referring Physician (Same as Primary ❑ Yes ❑ No)

Referring Physician	Phone	Fax
Office Address	City/State/Zip	
Email	Preferred Method of Communication ☐ Phone ☐ Email ☐ Fax ☐ Letter	

IMPORTANT | Please Note: Please include completed **Sleep Screening Questionnaire and Medical History** with every referral.

Medical History | For Insomnia Patients Only: The following information is required: Documentation of sleep complaint, screening for anxiety and depression, and trial of at least one insomnia treatment and the effect of that treatment.

Physician Signature: _____ Date: _____

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UCI Sleep Medicine : Medical History

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Patient Name: _____

Date: _____

MR Number or Date of Birth: _____

Medical History (UCI Providers: Please forward most recent history, physical and clinical note)

Suspected Disorders

- ☐ Sleep Apnea
- ☐ Insomnia
- ☐ Restless Legs/Periodic Limb Movements
- ☐ Narcolepsy or disorder of excessive sleepiness
- ☐ Sleep walking/night terrors
- ☐ Other (specify) _____

_____

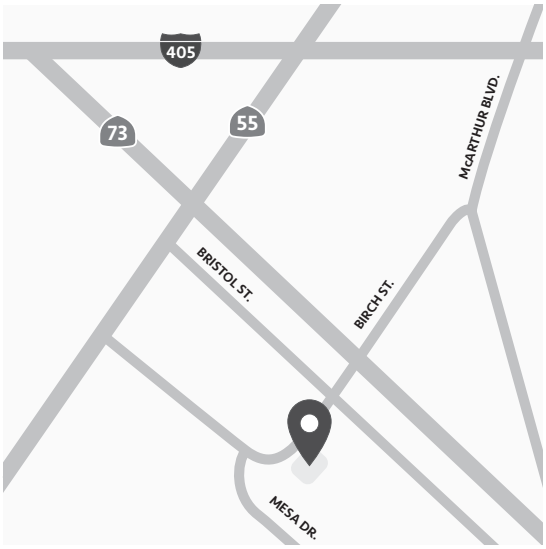
_____

Primary Symptoms

- ☐ Loud snoring
- ☐ Witnessed apneas
- ☐ Obese/large neck
- ☐ Morning headaches
- ☐ Daytime sleepiness
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Restless legs
- ☐ Sleep walking
- ☐ Nightmares
- ☐ Night terrors

Sleep needs

- ☐ Oxygen at night (_____liter/min)
- ☐ Interpreter (language _____)
- ☐ Wheelchair
  - ☐ Regular
  - ☐ Extra Large
- ☐ Other



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For Appts, call 714-509-2230
To refer a patient, fax 1-877-829-7891

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UCI Sleep Medicine : Patient Screening Questionnaire

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Patient Name: _____

Date: _____

MR Number or Date of Birth: _____

1. Do you snore loudly (loud enough to be heard through closed doors)?

☐ Yes ☐ No

2. Do you feel tired, fatigued, or sleepy during daytime?

☐ Yes ☐ No

3. Has anyone observed you stop breathing during your sleep?

☐ Yes ☐ No

4. Do you have or are you being treated for high blood pressure?

☐ Yes ☐ No

5. What is your height?

_____ Feet _____ Inches

6. What is your weight

_____ lbs

7. For males, what is your shirt neck size?

_____

8. Do you have unpleasant sensations (creepy-crawling, aching, pulling) in your legs combined with an urge to need to move your legs?

☐ Yes ☐ No

9. Do these sensations occur mainly or only at rest and do they improve with movement?

☐ Yes ☐ No

10. Are these sensations worse in the evening or night than in the morning?

☐ Yes ☐ No

11. Are these sensations bothersome to your sleep?

☐ Yes ☐ No ☐ N/A

12. Have you had a prior sleep study?

☐ Yes ☐ No

13. If you had a prior sleep study, when and where?

_____ /_____ (month/year)

at _____

14. Are you currently using CPAP?

☐ Yes ☐ No