Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

Patient Name: _____

Patient DOB: _____

Patient MRN: _____

Patient Phone: _____

SLEEP CLINIC CONSULTATION REFERRAL FORM

☐ Routine Sleep Consult

☐ Post-Discharge Referral

☐ Urgent Sleep Consult – Please select reason below :
(Reason must be provided for urgent booking)

- ❍ Problem with PAP equipment/Needs PAP replacement
- ❍ Severe OSA with severe nocturnal hypoxemia/severe oxygen desaturation
- ❍ Sleepy when driving
- ❍ Sleep symptoms are affecting job performance
- ❍ H/o severe COPD, respiratory failure or other severe lung disease, or neuromuscular disease
- ❍ H/o CHF, afib, severe pulmonary HTN, or recent stroke
- ❍ H/o epilepsy, or advanced dementia
- ❍ Scheduled surgery or medical procedure pending sleep evaluation
- ❍ Other, please specify: _____

Ordering Provider Information	
Name:	
Phone:	
Fax:	
NPI:	

Please complete this form and fax to 617-754-8619

Questions? Call 617-667-5864

NOTE: We schedule next available appointments across multiple locations and multiple providers.
Our team will contact your patient up to 2 times by telephone, and will follow up with a letter mailed to the home.
You can also submit an electronic order through a web-OMR Sleep Consult Order, under Orders Tab → "Sleep Consult".