The Connecticut Center for Sleep Medicine

Clinical Form for Adult Direct Referrals

Name **Primary MD** **Consult Req from:** **Date**

Questions	Yes/No	Doctors Comments Only
1. Are you tired / sleepy during the day?		
2. Have you noticed a decreased ability to concentrate or decreased memory?		
3. Do you get sleepy driving? Any accidents?		
4. Is your sleep refreshing?		
5. Do you snore?		
6. Do you ever have a choking feeling at night?		
7. Has anyone said you stop breathing at night?		
8. Do you have leg or arm discomfort at night that improves with movement?		
9. Do you move a lot while sleeping?		
10. Do you get sudden weakness in your body during emotional moments?		
11. Do you see or hear things that are not real when going to sleep or waking up?		
12. Do you ever feel paralyzed when you go to sleep or wake up?		
13. What is the average amount of sleep you get in a day?		
14. How many times do you wake up each night?		
15. Do you take naps?		
16. How long does it take you to fall asleep?		
17. # of caffeine beverages do you drink a day?		
18. # of alcoholic beverages do you drink a day?		
19. Do you smoke?		
20. How long have you had your sleep problem?		
21. Have you ever had a sleep study before?		
22. Have you ever been treated for a sleep problem? What was the treatment?		
23. Have you gained/ lost > 10 lbs in past 5yrs?		

List All Meds Including Herbal Preparations and Vitamins Check if listed in Referring MD's note ☐

List All Medical Problems Including Hospitalizations and Operations Check if listed in Referring MD's note ☐

List All Drug Allergies Check if listed in Referring MD's note ☐

Check if physical exam is listed in Referring MD's note ☐ **Height** **Weight**

History reviewed by _____ **MD** _____

***Note, sleep tests should not be ordered until this is signed** **Date** **Bed Time** **Rise Time**