Columbia Comprehensive Sleep Disorders Center
Neurology Division
710 West 168th Street, 7th Floor
New York, NY 10032
Tel.# (212) 305-1742-Fax# (212) 305- 1450

Referral for consultation/Sleep Study

Name:	Unit#
Address:	Home Phone:
Insurance:	Insurance Tel.#
Referring MD:	Referring MD Tel.#
Address:	DOB:

Referral (Circle): Consultation Sleep Study (polysomnography +/- MSLT)

If for sleep study, include simultaneous video-EEG Y N

Reason for referral: _____

Current Medications: _____

Diagnoses: _____

Please Note: It is preferred, and required by the American Academy of Sleep Medicine that patients, be evaluated by a sleep specialist prior to polysomnography. If consultation is not requested, please be as specific as possible about diagnostic questions and include copy of a completed evaluation**. Patients will be routinely schedule for a follow up appointment after the sleep test to discuss the results of the evaluation.**

CPAP titration or evaluation required: YN
(The neurology department sleep laboratory is not currently performing CPAP titration. These patients will be referred to Robert Basner, MD at The Pulmonary Department Sleep Laboratory).

For office use only:

Verification Date:	**Notes:**
Precert# /Date:	**Notes:**
Date Letter Mailed:	**Appt. Date/Time:**