Bristol Hospital Sleep Center

Main Entrance of Bristol Hospital
41 Brewster Road
Level E
Bristol, CT 06010
P: 860-585-3300
F: 860-314-6024

Sleep Experts:

- ★ Toshita Kumar, MD
- ★ Himanshu Rawal, MD
- ★ Keona Dawson- Camerota, APRN

PATIENT INFORMATION (REQUIRED)

Patient Name:_____ DOB: _____
Address:_____(City)_____(Zip)_____
Home Phone: _____ Cell Phone:_____
Primary Insurance:_____ Co- Insurance: _____
Subscriber Name:_____ Subscriber Name:_____
Subscriber #: _____ Subscriber #: _____

☐ **Submit Insurance Card**

SERVICE REQUEST:

☐ Sleep Consult (recommended for all referring physicians)- Testing, follow-up, & treatment by sleep physician
☐ Testing Only (referring physician orders test, treatment, and follow-up)
☐ Testing followed by Consult if testing is positive

TYPE OF TESTING: (Select only if testing applies)

☐ Polysomnography- Diagnostic
☐ Split Night (Diag/Titration) (AHI 40)
☐ Polysomnogram w/ Titration
☐ MSLT
☐ Home Sleep Test (Choose if patient has no Pulmonary/ Cardiac/ Neurological issues)

INDICATIONS FOR POLYSOMNOGRAPHY/ DIAGNOSTIC SLEEP STUDY (Required Information):

☐ Snoring	☐ Daytime Sleepiness	☐ Nocturnal sleep disruptions
☐ Morning Headaches	☐ Observed apnea or gasping	☐ Shift work Disorder
☐ Insomnia	☐ Other:	

INDICATIONS FOR TITRATION SLEEP STUDY (Required Information):

☐ Obstructive Apnea	☐ Daytime Sleepiness	☐ Nocturnal sleep disruptions
☐ Snoring	☐ Observed apnea or gasping	☐ Other:

☐ **Submit a copy of the physical exam.** Please note: A medical history and physical exam of patients referred for sleep testing is required for AASM accreditation and assists in testing authorizations.
☐ **Has the patient had a sleep study in the past?** If yes, please include a copy of study as well as other relevant information to avoid a delay in the patient's office visit or testing authorization.

Referring Physicians Name:_____ **Speciality:** _____
Referring Physician's Signature: _____ **Date:**_____**Time:**_____
Physicians Phone Number: _____ **Fax:** _____