RESPIRATORY AND SLEEP SPECIALISTS
POLYSOMNOGRAPHY REQUEST / REFERRAL FORM

Patient Details
Name: __________________________ DOB: __________________ Phone __________________

Area of Concern

Dental
☐ Chronic Gum Disease from mouth breathing
☐ Further assessment for Tonsil and Adenoid
☐ Large Tongue (or scalloped tongue)
☐ Snoring
☐ Night Time Teeth Grinding
☐ Nasal Valve Collapse
☐ Day Time Teeth Grinding
☐ Bell Shaped Palate (Narrow & Deep)
☐ Mouth Breathing/Dry mouth

Medical
☐ History of Stroke
☐ BMI
☐ High Blood Pressure
☐ Diabetes
☐ Heart Condition
☐ Memory/Concentration Issues
☐ High consumption of caffeine to stay awake
☐ Day time sleepiness

Other ____________________________________________________________________________
_________________________________________________________________________________

Referring Dentist
Dr __________________ Signature __________________________ Date ____________