**Neurology and Sleep Clinic**
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Certified by American Society of Neuroimaging

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Board Certified in Neurology
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## REQUEST FOR EVALUATION

☐***CONSULTATION-*** (Requesting Physician plans to be involved in the care of this patient for this problem)

☐***TRANSFER OF CARE***

☐***SLEEP STUDY:*** INTERPRETATION ☐ DR. SHAH ☐ REFERRING PHYSICIAN

☐ CONSULTATION WITH DR. SHAH AND APPROPRIATE SLEEP STUDY AND TREATMENT
☐ SLEEP STUDY ON FIRST NIGHT, AND CPAP TITRATION ON A SUBSEQUENT NIGHT (if necessary)
☐ SLEEP STUDY ONLY
☐ CPAP TITRATION ONLY
☐ MULTIPLE SLEEP LATENCY TEST (MSLT)
☐ MAINTAINENCE OF WAKEFULNESS TEST (MWT)

☐***EMG :*** ( ) Upper Limbs ( ) Lower Limbs

☐***EEG:***

Requesting Physician: _____ Phone: _____ Fax: _____

**Physician's signature (required):** _____ **Date:** _____

**Please save a copy of this form in the patient's chart.**

## PATIENT INFORMATION

Name: _____D.O.B: _____ SSN: _____

Ph- Home_____ Cell: _____ Work: _____

Primary Insurance: _____ Phone # to verify benefits: _____

Policy #: _____Group #: _____

Name of Policy Holder: _____ DOB: _____ SSN: _____

**Symptoms/Signs:**

| | | |
|---|---|---|
| ☐ARM AND NECK PAIN | ☐BELL'S PALSY | ☐BRAIN HEMORRHAGE |
| ☐BRAIN TUMOR | ☐CARPAL TUNNEL | ☐CONFUSION |
| ☐DIZZINESS-VERTIGO | ☐EXCESSIVE DAYTIME SLEEPINESS | ☐GAIT IMBALANCE-ATAXIA |
| ☐LEG AND BACK PAIN | ☐MEMORY LOSS | ☐MIGRAINES |
| ☐MUSCLE PAIN/CRAMPS/SPASMS | ☐MULTIPLE SCLEORISIS | ☐NEUROPATHY |
| ☐PARKINSON'S DISEASE | ☐SNORING, SLEEP APNEA | ☐SPEECH DISTURBANCE |
| ☐SEIZURES | ☐TIA / STROKE | ☐TINGLING/NUMBNESS |
| ☐TREMOR | ☐VISUAL DISTURBANCE | ☐ WEAKNESS |

☐OTHER DIAGNOSIS OR SYMPTOMS: _____-

PLEASE FAX THIS FORM AT (972) 306 6500 ALONG WITH:

1. RELEVANT OFFICE NOTES AND RELEVANT TEST RESULTS
2. INSURANCE CARD OR INFORMATION
3. GIVE FORM TO PATIENT. THE MAP FOR OFFICE IS ON THE BACK