[INSTITUTION NAME]

REFERRAL FOR: PHRENIC NERVE STIMULATION IMPLANT FOR CENTRAL SLEEP APNEA

Patient name: DOB:

From (Referring Physician): Specialty:

Referring Clinic Contact: Phone:

The above referenced patient is being referred to [CLINIC NAME and ELECTROPHYSIOLOGIST NAME] for evaluation for the **rem**edē® System implant for the treatment of central sleep apnea (CSA).

Patient to be followed by: ☐ Implanting Site or ☐ Referring Clinic

☐ Patient may be considered for phrenic nerve stimulation clinical trials at implanting site

COMPLETE THE FOLLOWING SECTIONS:

The patient has demonstrated moderate-to-severe CSA apnea based on the most recent sleep study:

Sleep study type: ☐ PSG ☐ HSAT Sleep study date (recommend within 2 years):

AHI (total):

☐ CAI ☐ CAHI ☐ OAI ☐ OAHI ☐ ODI4 ☐ ODI3

AS A RESULT OF CSA, THE PATIENT IS SYMPTOMATIC AND SUFFERS FROM:

☐ Fatigue
☐ Excessive daytime sleepiness
☐ Memory or concentration issues
☐ Mood changes
☐ Headaches
☐ Frequent nighttime awakenings
☐ Witnessed gasping or apneas at night

THE PATIENT HAS TRIED OR DECLINED, THE FOLLOWING THERAPIES:

DECLINED	FAILED	CONTRAINDICATED (LIST REASON)	THERAPY
☐	☐		Oxygen
☐	☐		CPAP
☐	☐		BiPAP
☐	☐	☐ Pt has LVEF < 45%	ASV
☐	☐		Medications:
☐	☐		Other:

OTHER MEDICAL CONDITIONS:

☐ Heart Failure ☐ Atrial Fibrillation ☐ Hypertension ☐ History of CVA/Stroke
☐ Other

☐ **Based on the above information, and clinical assessment, I feel that this patient is an appropriate candidate for phrenic nerve stimulation to treat moderate to severe central sleep apnea from a Sleep Medicine perspective.**

COMMENTS:

REFERRING PHYSICIAN SIGNATURE:

Please send patient's medical record to include PSG and office notes with this referral form.