Dr. Michael Baten is The Santa Fe SleepDoctor™
NEUROLOGY / ADULT AND PEDIATRIC SLEEP MEDICINE

Dr. Baten is a Neurologist/ Sleep Specialist with Neurological Associates as well as Medical Director of the CHRISTUS® St. Vincent Regional Sleep Center in Santa Fe
Dr. Baten is certified in sleep medicine by the American Academy of Sleep Medicine and the American Board of Psychiatry and Neurology
Dr. Baten understands sleep problems and may be able to help patients sleep better and help them again enjoy restful nights and wide awake days

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REFERRING A PATIENT WITH SLEEP PROBLEMS
FOR A SLEEP SPECIALIST CONSULTATION
OR A SLEEP STUDY (POLYSOMNOGRAM)

Sleep disorders affect 40 million people in the United States. They can lead to a decreased quality of life, impose medical risks and result in increased expenditures for health care. Therefore, accurate diagnosis is of paramount importance from health, social and economic standpoints.

There are two referral methods available:

Sleep Specialist Consultation. To have your patient seen by a board certified sleep physician, contact Michael Baten, MD at 505-983-8182. Once the patient has been seen, Dr. Baten will arrange for appropriate testing and follow-up. If the patient is referred for consultation, please complete the attached Consultation Referral Form and fax to us. Sleep testing will be performed as determined by Dr. Baten and you will be notified properly.

Direct referral for a sleep study at CHRISTUS® St. Vincent Regional Sleep Center. Sleep tests can be ordered by physicians, physician assistants and nurse practitioners. If the direct referral method is chosen the referring provider is responsible for all patient follow up. If you desire a direct referral, complete the attached Direct Referral Form and fax to the Sleep Center.

A Direct Referral requires two items from the referring physician:
- An order that is dated, identifies the patient, specifies the procedure requested, includes the referring diagnosis and is properly signed.
- A history and physical or clinical notes that address the need for a sleep study.
The American Academy of Sleep Medicine (AASM) provides recommendations regarding the indications for Polysomnography and related procedures in the diagnosis of sleep disorders, as follows.

**Polysomnography is routinely indicated for diagnosis of the following:**

- **Sleep-Related Breathing Disorders** consists of apnea (OSA-Obstructive Sleep Apnea) which is a cessation of respiration or a reduction of airflow. This is often associated with sleep fragmentation.
- **Neuromuscular Disorders and sleep-related symptoms** causing respiratory problems
- **Narcolepsy** which is characterized by abnormalities of sleep and the presence of excessive daytime sleepiness
- **Periodic Limb Movements** which are involuntary, repetitive limb movements that may occur during sleep and usually involve the legs and occasionally the arms. Often associated with RLS. This causes frequent arousals and leads to insomnia or excessive daytime sleepiness.
- **Sleep-Related Epilepsy**

**Polysomnography is not routinely indicated, but may be under certain conditions for diagnosis of the following:**

- **Restless Legs Syndrome** which is a neurologic disorder characterized by disagreeable leg sensations that usually occur at rest or before sleep and is alleviated by motor activity.
- **Parasomnias** which are undesirable physiologic phenomena that occur predominantly during sleep

**Polysomnography is NOT routinely indicated for diagnosis of the following:**

- **Insomnia**
- **Depression with Insomnia** which is characterized by difficulty with sleep associated with a psychiatric diagnosis. Problems include difficulty with sleep maintenance, with sleep onset, early morning awakenings and daytime fatigue.
- **Circadian Rhythm Sleep Disorders** which result from a mismatch between the sleep pattern and timing and amount of sleep that the person desires or needs. These include jet lag, shift work, irregular sleep-wake patterns, and delayed sleep-phase.
- **Excessive Daytime Sleepiness**

When sleep testing is not indicated by the diagnosis, please consider a sleep consultation with Dr. Baten.
Additional Information

Treatments for Sleep Disorders may include

**Bright Light Therapy** which is used to help treat disorders that result from a problem with the internal clock. Two of these disorders are jet lag and advanced sleep phase.

**Cognitive Behavioral Therapy (CBT)** These methods teach patients how to change actions or thoughts that hurt the ability to sleep well and help develop habits that promote a healthy pattern of sleep.

**Continuous Positive Airway Pressure (CPAP)** This is the most common and effective way to treat obstructive sleep apnea. A steady stream of air blows through a mask and into the back of the throat to keep the airway open.

**Medications.** A number of drugs have been developed to help treat some sleep disorders.

**Melatonin.** As a nutritional supplement, melatonin is most effective in the treatment of certain circadian rhythm sleep disorders.

**Oral Appliances.** These devices protect teeth and open the airway for sleep. They are used to treat teeth grinding, sleep apnea and snoring.

**Surgery**

**Home Sleep Tests.** The American Academy of Sleep Medicine (AASM) has endorsed the use of portable monitoring. Many insurance plans, including Medicare and Medicaid cover home tests if the patient meets the following criteria: they are between 18 and 65 years of age, have a high risk of moderate-to-severe sleep apnea, have no other major medical problems and have no other sleep disorders; or, if health or safety concerns prevent the patient from leaving home for a night.

Thank you for helping us provide the appropriate care for your patient.

Michael Baten, MD
SLEEP CONSULTATION REFERRAL FORM

We will contact the patient and schedule a time for our consultation after we have reviewed this form.

PATIENT'S NAME_________________________________________ DOB ___________________________

Patient's Home Phone_____________ Work Phone_____________ Cell Phone _______________

Address_________________________________ City, State, Zip _______________________________

Other Contact: Name____________________ Relation_____________ Phone ______________________

Special Needs__________________________

______________________________________________________________________________________

INDICATION FOR TESTING/ DIAGNOSIS

Snoring____________ OSA ______________ Apnea ________________

Daytime Sleepiness ____________ Insomnia ______________ RLS/PLMS ______________

Narcolepsy _______________ Other. Describe: _____________________________________________

______________________________________________________________________________________

REFERRING PHYSICIAN_________________________________ Specialty __________________________

Street Address_________________________________ City, State, Zip __________________________

NPI ___________________________________ Phone __________________ Fax __________________________

__________________________________                          _____________________________

Signature of Physician       Date
To: The CHRISTUS® St. Vincent Regional Sleep Center
Phone 505-913-5363   Fax 505-989-6409

DIAGNOSTIC SLEEP STUDY DIRECT REFERRAL FORM

A Direct Referral requires two items from the referring physician:
- An order that is dated, identifies the patient, specifies the procedure requested, includes the referring diagnosis and is properly signed.
- A history and physical or clinical notes that address the need for a sleep study (please attach)

PATIENT'S NAME_______________________________________________ DOB _____________________
Patient's Home Phone__________________ Work Phone_________________ Cell Phone _________________
Address_____________________________________ City, State, Zip _________________________________
Other Contact: Name __________________________Relation_______________ Phone __________________
Special Needs ______________________________________________________________________________

INDICATION FOR TESTING/ DIAGNOSIS

Snoring_______________ OSA _______________ Apnea _________________
Daytime Sleepiness _________________ Insomnia _________________ RLS/PLMS _________________
Narcolepsy _________________ Other. Describe: _____________________________________________
_______________________________________________________________________________________

REFERRING PHYSICIAN_________________________________ Specialty __________________________
Street Address __________________________ ____________City, State, Zip __________________________
NPI __________________________  Phone ________________________ Fax __________________________

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Signature of Physician       Date

This form is supplied by Michael Baten, MD The Santa Fe SleepDoctor™