WorkFitMedical
Occupational Health Services

Sleep Apnea
Medical Follow-Up

Patient's Name: _____ DOB: _____

Dear Doctor:

The employee named above was seen by our staff for a work related examination. In order for an Industrial Employee or driver of a Commercial Motor Vehicle to obtain or maintain certification when a medical condition is present, the patient must obtain medical follow-up from his/her personal physician documenting that the condition is diagnosed, treated, and under control.

The employee has been informed of the rationale for this follow-up request. By signing below, he/she gives approval to WorkFit Medical LLC to share documentation concerning this case with his/her personal physician.

We thank you in advance for completing this form and faxing it back to WorkFit Medical LLC at the clinic listed below.

Employee Signature: _____ Date: _____

Comments/Conditions: **Sleep Apnea**

- Physical has been screened with an Epworth Sleepiness Scale, which has revealed that patient is at risk for Sleep Apnea.
  - Score: _____
- According to DOT regulations, a Sleep Study needs to be performed confirming the presence or absence of sleep apnea for the patient noted above.
- Patient carries the diagnosis of Sleep Apnea.
- Please comment on stability and **include compliance data from CPAP machine from the past 90 days**

Requested by: _____

Please Complete and Verify:

1. The above named patient is under my medical supervision for the above condition and has been seen at my office within the last 6 months. ☐ Yes ☐ No Date of Last Visit: _____
2. Has a sleep study been performed to determine if the patient has sleep apnea? ☐ Yes ☐ No
3. Has the condition been addressed or treated and stabilized? ☐ Yes ☐ No
   If No, please comment on stability of the condition: _____
4. Current Treatment (If Medications, please attach list) _____
5. Is the patient compliant with treatment? ☐ Yes ☐ No
6. Have the driver's symptoms of sleepiness resolved? ☐ Yes ☐ No
7. In your opinion, can the above stated patient safely work without restrictions? ☐ Yes ☐ No
8. Does this patient have any other condition, which would interfere with his/her ability to work? ☐ Yes ☐ No

Doctor's Signature: _____ Date: _____
Printed Name: _____ Phone: _____
Office Address: _____ Fax: _____
_____

Workfit Use Only
Date Reviewed: _____
Provider Signature: _____

☐ **Employee meets follow-up requirements for ____ months.**
☐ **Employee does not meet follow-up requirements**
☐ **Other:** _____

Must Be Returned to WorkFit in 30 Days

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Rochester, NY 14624
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Batavia, NY 14020
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