Medical Status Form: *Sleep Disorders Review*

Fax form to 1-866-XXXXX

⇩ Employee Complete ALL Items ⇩

Name:	Employee ID:	Date of Birth:
Address:_____ _____ City State Zip	Home Phone: Home Email:	Job Title:

List all medications that you take regularly:

Treating Physician's Name, Address, Phone and Fax (print):

Name:_____ Phone:_____ Fax:_____

Address:_____ City:_____ State:_____ Zip:_____

I hereby authorize my physician to release any information except family medical history or genetic information that is requested with respect to my sleep disorder to the BNSF Medical & Environmental Health Department and/or its designees.

Employee Signature:_____**Date:**_____

⇩ Health Care Provider Complete ALL Items ⇩

Diagnosis:	**Next follow up appointment:**
Medication:	**Height:** **Current Weight:**

Is the patient experiencing any side effects of the medication: ❒ YES ❒ NO ⇨ If yes, explain,

Current blood pressure reading:	**If the employee has Sleep Apnea, is it:** **Mild ❒ Moderate ❒ Severe ❒**

Treatments: ☆If breathing machine is used: Please include type of device and settings

* According to the American Academy of Sleep Medicine Guidelines, compliance when using CPAP is using the machine > 4 hours 70% of the nights.

Is the patient compliant with the treatment guidelines: ❒ YES ❒ NO ⇨ If no, explain,

****attach compliance report from machine if available**

Is the patient having trouble staying awake and alert while at work: ❒ YES ❒ NO ⇨ If yes, explain,

Did patient require surgery? ❒ YES ❒ NO ⇨ If yes, explain including DATE and TYPE of surgery,

Diagnostic Tests: ☆Please include the results of any testing or lab work done

Health Care Provider Statement: This patient's sleep disorder stable, he/she is compliant with his/her treatment plan and he/she is safe and able to continue working in his/her safety sensitive position with the railway.

Health Care Provider's signature:__________**Date:**_____

Printed Name and Degree:_____