

Phone# 1-800-388-7722



Fax# 1-800-774-1491
*Please fax with patient demographics

Date: ___/___/___

SLEEP STUDY ORDER FORM

Patient name: _____ Patient Contact Number(s): _____

Patient address: _____

Referring Physician: _____ Interpreting Physician: _____

Please check symptoms that describe the patient's sleep complaint(s).

MAJOR CRITERIA: (Patient only has to meet one of these criteria)

- | | |
|-----------------------|---|
| _____ Witnessed apnea | _____ Loud snoring with disrupted sleep |
| _____ Morbid obesity | _____ Pathological hypersomnolence |

MINOR CRITERIA: (If patient does not meet one of the major criteria, he/she should meet at least two of the following)

- | | |
|-------------------------|--|
| _____ Snoring | _____ Abnormal oropharyngeal exam
(including tonsillar enlargement) |
| _____ Daytime fatigue | _____ Nocturnal choking |
| _____ Morning headaches | _____ Polycythemia (unexplained) |
| _____ Hypertension | _____ Restless Sleep |

Would you like to refer your patient for:

_____ Evaluation and screening with interpreting physician prior to sleep study

OR

- | | | |
|-------------------------------------|--|--|
| _____ NPSG (Diagnostic Sleep Study) | _____ NPSG with Nasal CPAP | _____ Combined study
(Performed per current protocol for split
nights as directed by Medical Director) |
| _____ Post-Operative NPSG | _____ Multiple Sleep Latency Test
(pathological daytime sleepiness) | |

Would you like to refer your patient to our interpreting physician for all diagnosed sleep disorders including ordering the CPAP unit if necessary? _____ Yes _____ No

Is patient on oxygen therapy? _____ Yes _____ No

Special Notes/Instructions:

Your patient will need to bring his/her own sleep aid if you would like for them to have it for their sleep study.

I have referred the above patient for a medically necessary sleep diagnostic study for the reasons indicated on this form. I am aware that this patient may require two sleep studies and will be scheduled for the second study according to written protocol which states that if the RDI for the first study is >20, then the second study will be performed to titrate CPAP to the appropriate pressure.

Physician Signature: _____ Date: _____