TriCity Lung & Sleep

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PULMONARY & SLEEP MEDICINE

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SLEEP CENTER ORDER FORM

Patient name: _____ D.O.B. _____

Please send patient demographics and visit note or H&P indicating need for sleep study

Primary Insurance: _____

SLEEP DIAGNOSIS/ INDICATIONS

- ☐ Obstructive sleep apnea
- ☐ Central sleep apnea
- ☐ Insomnia
- ☐ PLMD/RLS
- ☐ Hypersomnia
- ☐ Narcolepsy

PULMONARY DIAGNOSIS/ INDICATIONS

- ☐ Shortness of Breath
- ☐ COPD
- ☐ Asthma
- ☐ Pulmonary Fibrosis
- ☐ Hypoxia
- ☐ Other: _____

Sleep Problems *(for Sleep Medince Referrals)*

- ☐ Excessive daytime sleepiness
- ☐ Loud snoring
- ☐ Witnessed apnea (stop breathing while asleep)
- ☐ Wake up gasping or choking
- ☐ Morning headaches
- ☐ Trouble falling asleep or maintaining sleep
- ☐ Frequent awakenings
- ☐ Fall asleep driving or at undesired times
- ☐ Body paralysis triggered by emotions
- ☐ Vivid dreams or hallucinations
- ☐ Sleep paralysis
- ☐ Inadequate hours allowed for sleep time
- ☐ Restless legs preventing sleep
- ☐ Feel depressed or anxious
- ☐ Abnormal movements during sleep
- ☐ Other: _____

Past Medical History

- ☐ Congestive heart failure
- ☐ COPD/ lung disease
- ☐ High blood pressure
- ☐ Cornary artery disease
- ☐ History of stroke
- ☐ Obesity
- ☐ Seizure disorder
- ☐ Depression/bipolar
- ☐ Currently uses CPAP/BiPAP
- ☐ Uses supplemental oxygen
- ☐ Special needs:
- ☐ Other: _____

Physical Examination

Height: _____ Weight: _____ BMI: _____ Neck circumferences in inches: _____

SLEEP TESTING

- ☐ Office Consultation with sleep specialist physician
- ☐ Diagnostic Sleep Testing
- ☐ INSPIRE/Alternative treatment Qualification

PULMONARY TESTING

- ☐ Pulmonary Function Testing
- ☐ 6 Minute Walk Test/ Respiratory Stress Test

*All referrals are reviewed to ensure applicable clinical/ insurance guidelines are followed. Comprehensive follow up offered to all patients.

Physician Name (printed): _____ Phone: _____

Physician Signature: _____ Date: _____