

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: _____	Insurance authorization needed? <input type="checkbox"/> yes <input type="checkbox"/> no
(if yes) Auth # _____	For service: _____ Verified by (initial) _____

DIAGNOSIS/ INDICATIONS

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

HISTORY

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

PRESENT MEDICAL PROBLEMS

- | | | |
|---|---|--|
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> History of stroke | <input type="checkbox"/> Currently uses CPAP/BiPAP |
| <input type="checkbox"/> COPD/ lung disease | <input type="checkbox"/> Obesity | <input type="checkbox"/> Uses supplemental oxygen |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> Special needs: |
| <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Depression/bipolar | <input type="checkbox"/> Other: _____ |

PHYSICAL EXAMINATION

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

TEST ORDERED

- ☐ Office Consultation with sleep specialist physician
☐ Diagnostic Sleep Testing
☐ Preference for In-lab Sleep Testing ☐ Preference for Home Sleep Apnea Testing
☐ INSPIRE/Alternative treatment Qualification
☐ Daytime nap test (MSLT)
☐ CPAP or Bi-level PAP titration

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: _____