



Patient Name: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Phone (home): \_\_\_\_\_ Physician Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

(Work / Cell): \_\_\_\_\_ Physician NPI#: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Reason for study: \_\_\_\_\_

**Type of study requested:**

**Sleep Study and Treatment**

Includes diagnostic overnight sleep study (PSG), CPAP titration if criteria met, post study consult and PAP therapy initiation (if indicated).

**CPAP Trial**

Full night CPAP titration for patients following a recent polysomnogram and documented sleep apnea.

**Diagnostic Sleep Study and Multiple Sleep Latency Test (MSLT)**

Diagnostic daytime nap test following a full night diagnostic PSG study for the evaluation of excessive sleepiness and narcolepsy.

**Sleep Study Only (Results sent to referring physician for further management.)**

Full night polysomnography (PSG).

**Therapy Only:**

**CPAP Therapy Program**

Visit with a CPAP therapist for evaluation and training, initiation of therapy, mask fitting, compliance management or equipment assessment.

**Oral Appliance Evaluation and Treatment**

Evaluation and fabrication (as appropriate) of oral appliance to treat snoring or sleep apnea.

Special Instructions: \_\_\_\_\_

**SYMPTOMS:** (check all that apply)

_____ breathing pauses	_____ daytime sleepiness	_____ insomnia	_____ restless sleep
_____ cataplexy	_____ fatigue	_____ leg movements	_____ snoring
_____ cognitive difficulties	_____ incontinence	_____ nocturnal awakenings	_____ other

**MEDICAL HISTORY:** (check all that apply) PLEASE FORWARD A RECENT HISTORY AND PHYSICAL OR RECENT OFFICE NOTE WITH THIS REFERRAL.

_____ allergies	_____ asthma/COPD	_____ heart disease	_____ stroke
_____ anemia	_____ diabetes	_____ headaches	_____ thyroid disease
_____ anxiety disorder	_____ depression	_____ HTN	_____ other
_____ arrhythmia	_____ epilepsy	_____ neuromuscular disease	
_____ arthritis	_____ GE reflux-gastritis/PUD	_____ sinus disease	

Medications and/or comments: \_\_\_\_\_

Patient's Insurance Company: \_\_\_\_\_ Insurance Company Phone: \_\_\_\_\_

Insured Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Insurance Member #: \_\_\_\_\_

Referring Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_