

Patient Label or
Patient Name
DOB or MR#

Adult Sleep Study Order Set

FAX ALL DOCUMENTS TO:

Surgery & Diagnostic Scheduling

Fax 531-355-0026

Phone 531-355-6737

Today's Date: _____

Referring Provider: _____ Phone: _____

Provider Specialty: _____ Fax: _____

Thank you for referring your patient to the Sleep Disorders Center. Please fax the following information so we can provide the best and most timely service:

- Insurance and Demographic information
- Most recent H & P and/or clinic note on the patient you are referring

Patient Name: _____ Date of Birth: _____ Phone: _____

Adult Sleep Study Requested:

- Home Sleep Study
- Adult Sleep Study Split night if qualifies
- PAP Titration Sleep Study current PAP settings _____

Comments: _____

Current Diagnoses (check all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Obstructive Sleep Apnea | <input type="checkbox"/> Choking / Gasping |
| <input type="checkbox"/> Morning headaches | <input type="checkbox"/> Central Sleep Apnea | <input type="checkbox"/> Sleep Disturbance |
| <input type="checkbox"/> Witnessed Apnea | <input type="checkbox"/> Daytime Sleepiness | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Restless Leg Syndrome | <input type="checkbox"/> Periodic Limb Movements | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Other _____ | | |

Provider Signature: _____ Date: _____ Time: _____