Your Hospital's Logo Here

SLEEP DISORDERS INSTITUTE
HOSPITAL: DePaul Building
Street Address
City, State Zip
Tel: (202) 555 - 1212
Fax: (202) 555 - 1212

REQUEST FOR SLEEP STUDY

INSTRUCTIONS TO PHYSICIAN:

Please complete this form, and return by fax to (202) 555-1212
The Centers' Sleep Care Specialist will contact the patient to schedule tests that you have ordered.

PATIENT INFORMATION:

PATIENT NAME:		DATE OF BIRTH: / /
PATIENT ADDRESS:		
CITY:	STATE:	ZIP:
HOME TELEPHONE:	WORK TELEPHONE:	
INSURANCE CARRIER:	ID NUMBER:	
M R #:	ACCOUNT #:	SDI IDENTIFICATION #:

TYPE OF VISIT REQUESTED:

☐ I request that the visit / procedure be determined by a board-certified physician at the Sleep Disorder Center.

☐ Initial Consultation ☐ Follow-Up Visit ☐ Nocturnal Polysomnograph ☐ Nasal CPAP Titration
☐ Multiple Sleep Latency Test ☐ Cardiac Monitoring (Holter) ☐ Maintenance of Wakefulness Test (MWT)
☐ Other _____

PATIENT REFERRED TO EVALUATE THE FOLLOWING

☐ Sleep Apnea ☐ Restless Legs ☐ Narcolepsy ☐ Periodic Limb Movement Disorder
☐ Insomnia ☐ Daytime Sleepiness ☐ Other _____

PATIENT HISTORY

Snoring:	☐ YES	☐ NO
Grasping or choking during sleep:	☐ YES	☐ NO
Apneic events witnessed by partner:	☐ YES	☐ NO
Discomfort or restlessness of lower limbs before / during sleep:	☐ YES	☐ NO
Twitching, jerking, or kicking of lower limbs before or during the sleep period:	☐ YES	☐ NO
Daytime sleepiness or fatigue:	☐ YES	☐ NO

HEIGHT: _____ ft _____ in	WEIGHT: _____ lbs	B P: _____ / _____

MEDICAL CONDITIONS:

CURRENT MEDICATIONS:

ASSISTANCE REQUIRED FOR AMBULATION, TOILETING, OR OTHER ACTIVITIES?
☐ NO ☐ YES: PLEASE EXPLAIN > >

REFERRING PHYSICIAN

NAME:		TELEPHONE:
ADDRESS:		UPN #:
CITY:	STATE:	ZIP:
SIGNATURE:	FAX #:	E-MAIL:

PART OF THE MEDICAL RECORD