

**Please fill out this form completely and fax along with patient's History & Physical and insurance cards.**

**SECTION 1 - PATIENT INFORMATION**

Name: \_\_\_\_\_  
 SSN: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Work Phone: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**SECTION 2 - CLINICAL OBSERVATIONS AND PHYSICAL FINDINGS**

**Presenting Symptoms & Physical Findings**    *Diagnosis Code:* \_\_\_\_\_

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Observed Apnea               | <input type="checkbox"/> Non-Restorative Sleep  | <input type="checkbox"/> Enlarged Neck Circumference     |
| <input type="checkbox"/> Awakens gasping for breath   | <input type="checkbox"/> Creeping/Crawling Legs | <input type="checkbox"/> Enlarged Tongue                 |
| <input type="checkbox"/> Morning Headaches            | <input type="checkbox"/> Leg Restlessness/Jerks | <input type="checkbox"/> Worn Teeth                      |
| <input type="checkbox"/> Sleep Walking                | <input type="checkbox"/> Excessive Somnolence   | <input type="checkbox"/> Enlarged Tonsils                |
| <input type="checkbox"/> Frequent Awakenings          | <input type="checkbox"/> Seizures               | <input type="checkbox"/> Maxillomandibular Abnormalities |
| <input type="checkbox"/> Loud Snoring                 | <input type="checkbox"/> Syncope                | <input type="checkbox"/> Crowded Oropharynx              |
| <input type="checkbox"/> Pathological "Sleep Attacks" | <input type="checkbox"/> Impaired Cognition     | <input type="checkbox"/> Mood Disorders                  |
| <input type="checkbox"/> Other: _____                 |   |  |

**MEDICAL HISTORY**

- |                                 |                                   |                                       |   |   |
|---------------------------------|-----------------------------------|---------------------------------------|---|---|
| <input type="checkbox"/> CHF    | <input type="checkbox"/> Obesity  | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Hypertension       | <input type="checkbox"/> Cardiac Arrhythmias        |
| <input type="checkbox"/> COPD   | <input type="checkbox"/> CVA      | <input type="checkbox"/> Neuropathy   | <input type="checkbox"/> Dementia           | <input type="checkbox"/> Ischemic Heart Disease     |
| <input type="checkbox"/> OSA    | <input type="checkbox"/> GERD     | <input type="checkbox"/> Depression   | <input type="checkbox"/> Stroke             | <input type="checkbox"/> Fibromyalgia               |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anxiety      | <input type="checkbox"/> Mental Retardation | <input type="checkbox"/> Connective Tissue Disorder |

**SECTION 3 - STUDY ORDER INFORMATION**

- |  |   |
|--|---|
| <input type="checkbox"/> <b>Complete Sleep Referral:</b> <i>Patient seen by sleep physician with all appropriate testing done and equipment set up, if needed.</i> |   |
| <input type="checkbox"/> Baseline PSG  | <input type="checkbox"/> MWT  |
| <input type="checkbox"/> All Night PAP Titration (CPAP/Bilevel PAP)  | <input type="checkbox"/> ETCO2 Monitoring                               |
| <input type="checkbox"/> Split Night (PAP initiated if severe to mod. OSA)   | <input type="checkbox"/> Standard EEG                                   |
| <input type="checkbox"/> Auto SV PAP Titration   | <input type="checkbox"/> Sleep Deprived EEG                             |
| <input type="checkbox"/> Narcolepsy study ( <i>Baseline PSG with next day MSLT</i> )   | <input type="checkbox"/> Ambulatory EEG: 24 or 48 hour (circle choice)  |
| <input type="checkbox"/> MSLT only   | <input type="checkbox"/> EEG w/ Video: 2 4 6 or 8 hours (circle choice) |

**SECTION 4 - INTERPRETING PHYSICIAN**

- |  |  |
|--|--|
| <input type="checkbox"/> David Henson, Medical Director (Sleep, adult) | <input type="checkbox"/> Daniel Donovan (EEG/Sleep, adult/pediatric) |
| <input type="checkbox"/> Vijay Rupan (Sleep, adult)                    | <input type="checkbox"/> Dalia Miller (EEG/Sleep, adult)             |
| <input type="checkbox"/> Thuy Ngo (EEG/Sleep, adult)                   | <input type="checkbox"/> Doug Kane (Pulmonary, adult)                |
| <input type="checkbox"/> Russell Gibson (Sleep, adult/pediatric)       | <input type="checkbox"/> No Preference _____                         |

**OFFICE USE ONLY:**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Print Physician Name: \_\_\_\_\_  
 Phone #: \_\_\_\_\_ FAX #: \_\_\_\_\_