



SLEEP STUDY ORDER FORM

To schedule appointment **complete** form and fax with copy of insurance card to: **770.832.9529**
or call: **770.832.2775, ext. 11**

Patient Name: _____ Sex: _____ DOB: _____ SS#: _____

Daytime Phone: _____ Cell / Work Phone: _____ Height: _____ Weight: _____

Address: _____ Insurance Plan: _____

Please check requested procedure(s):

We pre-certify all procedures prior to testing

_____ **Sleep Study:** I (referring physician) will see my patient back in follow-up before further testing is done. Yes ___ No** ___

_____ **CPAP/Bi-PAP Study:** I (referring physician) will see my patient back in follow-up to discuss results. Yes ___ No ___

_____ **** 2 Night Protocol:** (A 2nd night will be automatically scheduled for CPAP/Bi-PAP titration if 1st night data shows OSAS)

_____ **MSLT:** Multiple Sleep Latency Test, (a daytime study that must be preceded by an overnight Sleep Study for an accurate evaluation)

_____ **Split Night Study** (Sleep Study and CPAP/Bi-PAP titration study in the same night) **Note:** *patient must meet their insurance clinical criteria*

_____ **Sleep Consultation** (Pt. will see our Dr. for initial office visit and work-up followed by testing and treatment as needed)
(For more order forms visit: Cannot-Sleep.com)

Special Instructions:

_____ Ambien, 5-10mg at (Sleep Study) bedtime (Prescription required from referring Dr) **Do not order Ambien if MSLT is ordered**

_____ Administer nasal O2 to maintain SaO2 ≥ _____%. Does patient have COPD? Yes ___ No ___

CPAP/Bi-PAP Set-up: (Please check preferred process)

_____ I (referring physician) will discuss study results with my patient and decide next plan of action. If I recommend WGSDC for CPAP/Bi-PAP equipment set-up, I will direct my patient back to your facility with a prescription for CPAP or Bi-PAP.

_____ I prefer West Georgia Sleep Disorders Center’s professional staff initiate and pre-certify the DME which includes: the discussion of results with my patient, prescription for CPAP/Bi-PAP set-up, and CPAP/Bi-PAP clinic follow-up(s) with their respiratory therapist. Send all correspondence/updates on patient’s progress to my office. **Note:** *WGSDC cannot provide DME to Medicare/Medicaid patients however, as a convenience we can arrange and refer your patient to a local DME company of their choosing.*

Presenting Symptoms/Exam:

- | | | |
|------------------------------------|--------------------------------|---------------------------------|
| _____ Loud Snoring | _____ Non-restorative sleep | _____ Sleep paralysis |
| _____ Excessive Daytime Somnolence | _____ Morning headaches | _____ Leg restlessness or jerks |
| _____ Observed apnea | _____ Morning dry mouth | _____ Enlarged tonsils |
| _____ Awakening gasping for breath | _____ Nasal obstruction | _____ Obesity |
| _____ Hypertension | _____ Cataplexy/hallucinations | _____ Short term memory loss |
| _____ Drowsy driving | | |

Suspected diagnosis:

- | | |
|---|------------------------------------|
| _____ Obstructive sleep apnea w/Hypersomnolence | _____ Sleep/Wake Cycle Disturbance |
| _____ Obstructive sleep apnea w/Insomnia | _____ Narcolepsy/Cataplexy |
| _____ Sleep Stage Disturbance | _____ Insomnia |
| _____ Periodic Leg Movements of Sleep | _____ UARS |
| _____ Other Sleep Disorders (specify): _____ | |

I (referring physician) authorize the above tests to be completed and interpreted for the purpose of evaluating the above complaints and diagnoses.

Print Referring Physician Name _____ **Signature** _____ **Office Phone** _____ **Date** _____

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