



Phone: (931) 783-2762
Fax: (931) 783-2036

Patient Name: _____

SSN: _____ DOB: _____ Primary Care Physician _____

Primary Phone: _____

Address: _____

Male Female Height: _____ Weight: _____

Please include patient's current medical history, insurance card, and most recent history and physical.
***** A valid Test Order and recent H&P (detailing pt's sleep symptoms) is required to schedule a sleep study*****
Include ALL symptoms that warrant testing. Patient must have a sleep complaint with appropriate symptoms:

PRIMARY SLEEP SYMPTOMS (CHECK ALL THAT APPLY):

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

CONTRIBUTING SYMPTOMS (CHECK ALL THAT APPLY):

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

SPECIAL NEEDS: Pts who are in a nursing home or need any type of nursing care are required to bring someone to assist them. We do not provide or administer medications. Pts who exhibit signs of a medical emergency will be evaluated by appropriate medical personnel and may be taken to the ER.

- Supplemental O2 @ ___ lpm (O2 will not be used during study unless O2 protocol is met)
- Wheelchair Blind Needs Daytime Study
- Language Barrier Other Instructions: _____

TEST NEEDED: (A Home Sleep Test will be performed in place of a Polysomnogram if mandated by patient's insurance company)

- | | | |
|--|---|--|
| <input type="checkbox"/> Home Sleep Test | <input type="checkbox"/> Baseline PSG | <input type="checkbox"/> Split Night |
| <input type="checkbox"/> All night PAP Titration (Circle one: CPAP/Bilevel PAP) | <input type="checkbox"/> ETCO2 Monitoring | |
| <input type="checkbox"/> ASV Titration | <input type="checkbox"/> MSLT (Must also select baseline PSG) | <input type="checkbox"/> MWT (Must also select baseline PSG) |
| <input type="checkbox"/> COMPLETE SLEEP REFERRAL: (Patient MUST be seen by sleep physician BEFORE testing) | | |

INTERPRETING PHYSICIAN:

- | | |
|--|--|
| <input type="checkbox"/> No Preference | <input type="checkbox"/> Dr. James Davis, Sleep Center Staff (Adult/Pediatric) |
| | <input type="checkbox"/> Dr. Daniel Donovan (EEG/Sleep, Adult/Pediatric) |

APPT. DATE:

PRE CERT. #:

Signature: _____ Date: _____

Print Physician Name: _____

Phone #: _____ FAX #: _____