COOKEVILLE REGIONAL
MEDICAL CENTER
SLEEP CENTER

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):

❑ Observed Apnea	❑ Non-Restorative Sleep	❑ Impaired Cognition	❑ Syncope
❑ Awakens gasping	❑ Creeping/Crawling Legs	❑ Mood Disorders	❑ Enlarged Tonsils
❑ Morning Headaches	❑ Leg Restlessness/Jerks	❑ Enlarged Neck	❑ Crowded Oropharynx
❑ Loud Snoring	❑ Excessive Somnolence	❑ Enlarged Tongue	❑ Maxillomandibular Abnormalities
❑ "Sleep Attacks"	❑ Seizures	❑ Worn Teeth	

❑ Other: _____

CONTRIBUTING SYMPTOMS (CHECK ALL THAT APPLY):

❑ CHF	❑ Obesity	❑ Hypertension	❑ Cardiac Arrhythmias	❑ Depression
❑ COPD	❑ CVA	❑ Dementia	❑ Ischemic Heart Disease	❑ Chronic Pain
❑ OSA	❑ GERD	❑ Stroke	❑ Fibromyalgia	❑ Neuropathy
❑ Asthma	❑ Diabetes	❑ Anxiety	❑ Intellectual Disability	❑ 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)**

❑ Home Sleep Test ❑ Baseline PSG ❑ Split Night

❑ All night PAP Titration (Circle one: CPAP/Bilevel PAP) ❑ ETCO2 Monitoring

❑ All night PAP Titration ❑ MSLT (Must also select baseline PSG) ❑ MWT (Must also select baseline PSG)

❑ COMPLETE SLEEP REFERRAL: (Patient MUST be seen by sleep physician BEFORE testing)

INTERPRETING PHYSICAN:

❑ No Preference ❑ Dr. James Davis, Sleep Center Staff (Adult/Pediatric)

❑ Dr. Daniel Donovan (EEG/Sleep, Adult/Pediatric)

APPT. DATE:
PRE CERT. #:

Signature: _____ Date: _____

Print Physician Name: _____

Phone #: _____ FAX #: _____