



COOKEVILLE REGIONAL
MEDICAL CENTER
SLEEP CENTER

Phone: (931) 783-2762
Study Fax: (931) 783-2036
Referral Fax: (931) 783-2656

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
- ☐ ASV 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 PHYSICIAN:

- ☐ No Preference ☐ Dr. James Davis, Sleep Medicine (Adult/Pediatric)
- ☐ Dr. Kyrillos Ghattas, Sleep Medicine (Adult/Pediatric) ☐ Dr. Daniel Donovan (EEG/Sleep, Adult/Pediatric)

APPT. DATE:

PRE CERT. #:

Signature: _____ Date: _____

Print Physician Name: _____

Phone #: _____ FAX #: _____