

REQUEST FOR CLINICAL POLYSOMNOGRAPHY

Please complete this form and return by fax to 212.994.5101. The Institute's Sleep Care Specialist will contact the patient to schedule tests that you have ordered. This form is not an insurance referral. Your patient may need to contact his/her primary care physician to obtain a valid insurance referral.

PATIENT INFORMATION

PATIENT NAME _____ DATE OF BIRTH ___/___/___
ADDRESS _____
HOME _____ MOBILE _____ WORK _____
INSURANCE CARRIER _____ ID NUMBER _____

TYPE OF VISIT / TEST REQUESTED

- I request that the visit or procedure be determined by a physician at the Sleep Disorders Institute.**
- Initial Consult
 Follow-Up Visit
 Nocturnal Polysomnogram
 Nasal CPAP Titration
- Unattended In-Home Testing
(for R/O OSA only & pending insurance approval)
- Split Night
 Multiple Sleep Latency Test
 Maintenance of Wakefulness Test (MWT)
- Other _____

PATIENT REFERRED TO RULE OUT OR CONFIRM THE FOLLOWING

- Sleep Apnea Daytime Sleepiness Periodic Limb Movement Disorder
 Insomnia Restless Legs Narcolepsy Other _____

PATIENT HISTORY

- Snoring..... Yes No
Gasping or choking during sleep..... Yes No
Apneic events witnessed by bed partner..... Yes No
Discomfort or restlessness of lower limbs before or during the sleep period..... Yes No
Twitching, jerking, or kicking of lower limbs before or during the sleep period..... Yes No
Daytime sleepiness or fatigue..... Yes No
Previous diagnosis of OSA?..... Yes No
 If yes, is patient on CPAP?..... Yes No
 If on CPAP, at what pressure?..... _____
 Has upper airway surgery been performed?..... Yes No
Is this request for a sleep study for pre-operative evaluation prior to bariatric surgery?..... Yes No
To help with scheduling, when do you plan to have a follow-up appointment with this patient? _____
Height _____ ft. _____ in. Weight _____ lbs. Blood Pressure _____ / _____
Medical Conditions (include recent surgeries) _____
Current Medications _____
Allergies _____
Is the patient a commercial driver?..... Yes No
Is assistance required for language translation, ambulation, toileting, or other activities? If yes, please explain: _____

REFERRING PHYSICIAN

NAME _____ TELEPHONE _____
SPECIALTY _____ REFERRAL DATE _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____ NPI# _____
SIGNATURE _____ FAX _____ E-MAIL _____

REPORT PREFERENCES

- Call with test results prior to issuance of report
Send report by Mail Fax
- Has this patient been to the Sleep Disorders Institute before?
 Yes No If a previous sleep study has been performed at another center, please send a copy of the report.

