

FAX to 404.712.8145 with most recent History & Physical Notes

- Sleep specialist consultation and management **ONLY**
- Emory Midtown - Sleep specialist consultation and management **ONLY**

Patient Name _____ D.O.B. ____/____/____ Height _____ Wt _____ lbs.
 Patient Phone Numbers: (____) _____ Home (____) _____ Alternate
 Usual Workday Bedtime _____ AM/PM Usual Non-Workday Bedtime _____ AM/PM

STUDY REQUESTED (Order Required to Schedule Study):

- Standard Sleep Study (Split) Will include CPAP initiation and titration if appropriate clinical criteria are met. *If criteria are met too late for treatment, patient will be scheduled for a subsequent CPAP titration night.*
- Screening Sleep Study All night diagnostic PSG. CPAP will not be applied unless severe apnea is present.
- All Night PAP Titration **OSA or UARS must already be PSG-documented. Date of previous PSG: ____/____/____**
 Positive airway pressure will be titrated to optimal pressure level.
- Narcolepsy Study ____ CPAP ____ BiPAP * *** CPAP must be previously proven ineffective**
 All night sleep study with next day MSLT (Multiple Sleep Latency Test)
- Other:



CPAP Management Wesley Woods

I authorize Emory Sleep Center to coordinate home CPAP therapy within 48 hours following the study through a participating DME vendor. Patient will be set up on auto titrating device with a setting of 6cm/H2O to increase to a maximum pressure of 3cm/H2O above optimal pressure with heated humidifier. Overnight oximetry to be performed to assess oxygenation 1 week following set up of CPAP for patient with severe OSA or hypoxia. **BIPAP titrations will require a separate script which will be sent the morning following testing.**
 A consultation with a sleep specialist will be scheduled approximately 2 weeks after the sleep study to review and manage CPAP adherence.

CPAP Management Emory Midtown: A consultation with a sleep specialist will be scheduled for the patient at the Emory Midtown location after the sleep study to review and manage CPAP adherence. For further information please contact 404.868.2505.

INDICATIONS FOR SLEEP STUDY (Required to demonstrate Medical Necessity):

- Obstructive Sleep Apnea (327.23)
- Periodic Limb Movement Disorder (327.51)
- Unspecified Sleep Apnea (780.57) *
- Central Apnea (327.21)
- Narcolepsy (347.00)
- Parasomnias (327.40)
- Phase Delay (327.31)
- Other: _____

SLEEP SYMPTOMS / HISTORY (Please Check Appropriate Boxes):

MEDICAL HISTORY

- | | | | | |
|---|---|---|---|--|
| <input type="checkbox"/> Excessive Daytime Sleepiness * | <input type="checkbox"/> Morning Headaches | <input type="checkbox"/> Cataplexy | <input type="checkbox"/> Seizures | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Snoring * | <input type="checkbox"/> Sleep Walking or Talking | <input type="checkbox"/> Weight Loss/Gain | <input type="checkbox"/> Sinusitis / Rhinitis | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Witnessed Apneas * | <input type="checkbox"/> Nightmares or Night Terrors | (to ascertain optimal PAP) | <input type="checkbox"/> Allergies | <input type="checkbox"/> CHF |
| <input type="checkbox"/> Overweight (BMI: _____) | <input type="checkbox"/> REM Behavior Disorder | | <input type="checkbox"/> Impaired Cognition | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Insomnia / Fragmented Sleep | <input type="checkbox"/> Bruxism / Teeth Grinding | | <input type="checkbox"/> Mood Disorders | <input type="checkbox"/> Atrial Fibrillation |
| <input type="checkbox"/> Leg Cramps, Movement or Jerks | <input type="checkbox"/> Insufficient response to PAP | | <input type="checkbox"/> Diabetes | <input type="checkbox"/> COPD |
| | | | <input type="checkbox"/> Anxietv * | <input type="checkbox"/> Other: |

If your patient may be claustrophobic, consider prescribing a short-acting anxiolytic (e.g.; 0.5 to 1 mg. of lorazepam) for the patient to self-administer in the lab. If medication that may cause sedation is prescribed, advise the patient NOT to drive at the completion of the test.

SPECIAL NEEDS / ISSUES THAT MAY AFFECT PATIENT OR TECHNOLOGIST COMFORT/SAFETY:

Oxygen: ____ L/min. ____ Nocturnal ____ Dental Appliance ____ S/P; Upper Airway Surgery

- CPAP Compliance Problems
- Psychiatric Problems that may affect study (specify): _____

- Walker, Wheelchair, Assistance Walking
- Incontinence Problems
- Translator – Language: _____

Allergies: Tape Latex Talc

Medication Adverse Reaction: _____

Current Medications:
Technologists may NOT administer oral or injectable medications in the lab. The patient's medications can only be self-administered.

I authorize Emory Sleep Center to conduct the above named study.

Requesting Physician: _____ **Date:** __/__/__(REQUIRED) **NPI:** _____

Signature: _____ **(REQUIRED) Phone:** _____