

Patient Name \_\_\_\_\_

D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ Height & Weight **OR** BMI \_\_\_\_\_ Preferred Patient Phone #: (\_\_\_\_) \_\_\_\_\_

**REQUESTING PROVIDER PHONE AND FAX:** \_\_\_\_\_

REQUESTING PROVIDER (printed): \_\_\_\_\_ (signature): \_\_\_\_\_ date \_\_\_\_\_

**LAB STUDY and/or OFFICE VISIT OPTIONS:**

**Overnight Sleep Diagnostic Study 1<sup>st</sup>, followed by Clinic Visit w/ Sleep Doctor for results**

If Lab study denied due to insurance (check choice below) ↘

→  Proceed with Home Sleep Test --- **OR** ---  Notify me for peer to peer

**Clinic Visit w/ Sleep Doctor**

**Overnight Sleep Study Only** (follow up with ordering physician)

STUDY TYPE: \_\_\_\_\_

**Home Sleep Test** (please indicate if follow up preference is with Sleep or Referring doc: \_\_\_\_\_)

**HISTORY & PHYSICAL EXAM NOTES DOCUMENTING SPECIFIC SLEEP COMPLAINTS  
MUST BE IN EMORY EMR OR FAXED WITH ORDER (Required for scheduling)**

**Sleep Specialist Review:**  
Date: \_\_\_\_\_ Initials: \_\_\_\_\_  
Comments: \_\_\_\_\_

**DIAGNOSIS, HISTORY and SYMPTOMS for study: It is critical we have this information for authorizing test and showing medical necessity. Most recent office note should reflect this rationale and be available.**

**Diagnosis**

- Obstructive Sleep Apnea (G47.33)**
- Unspecified Sleep Apnea (G47.30)**
- Central Sleep Apnea (G47.31)**
- Hypoventilation Syndromes (G47.36)**
- Narcolepsy (G47.41)**
- Hypersomnia (G47.10)**
- Parasomnias (G47.50)
- Periodic Limb Movement (G47.61)
- Restless Leg Syndrome (G47.62)
- Insomnia (G47.00)\*\*\* (absent other suspected diagnoses refer to clinic)

**Past Medical History**

- Sleep Apnea
- Current CPAP Use
- Prior CPAP Use
- Hypertension
- Cardiac Disease History
- Stroke
- Pulmonary Hypertension
- Nocturnal oxygen desaturation or cardiac arrhythmias during sleep
- Obesity BMI >30 Kg/m2 \_\_\_\_\_
- Parkinson's Disease

**Symptoms (check all that apply)**

- Witnessed apneas during sleep
- Epworth > 10 (Score: \_\_\_\_\_)
- STOP-Bang > 3 (Score: \_\_\_\_\_)
- Awakens with choking or gasping
- Persistent snoring
- Daytime sleepiness
- MVC, sleeping while driving
- Hallucination (type: \_\_\_\_\_)
- Sleep paralysis
- Narcolepsy w/cataplexy or w/o
- Violent sleep behavior
- Periodic limb movements

**SPECIAL NEEDS AND INSTRUCTIONS:**

- Study should be performed on oxygen; liter flow: \_\_\_\_\_
- Patient uses walker, wheelchair, requires assistance for mobility
- Patient should wear dental appliance for study
- Incontinence
- Allergies:  Tape  Latex  Talc
- Interpreter required:
- Medication Adverse Reaction: \_\_\_\_\_
- Significant cognitive impairment:

Office Use: