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SOUTHEASTERN LUNG CARE
THE SLEEP DISORDERS CENTERS

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Pulmonary Disease • Critical Care Medicine • Sleep Medicine

DECATUR SLEEP FAX – 404-508-8576 / CONYERS SLEEP FAX – 770-483-3176
GREENSBORO SLEEP FAX – 762-445-1110 / JOHNS CREEK SLEEP FAX - 470-246-5419

Sleep Referral/Order Form

Please fill out this form completely and fax along with last office notes and insurance card
If the patient is a minor (under 18 years of age) a parent or guardian must stay with them for the duration of the study

Name: _____ Gender: _____ DOB: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Vitals/Epworth: **Height** _____ **Weight** _____ **B/P**_____ **BMI** _____ **Epworth** _____

Presenting Symptoms:

_____ Loud snoring
_____ Awakening gasping for breath
_____ Observed apnea
_____ Excessive daytime sleepiness
_____ Limb restlessness or jerks
_____ Non-restorative sleep
_____ Patient with positive PSG/HST
_____ Prior history of OSA
_____ Obesity
_____ Hypertension
_____ Breathing stops during sleep
_____ Sleep paralysis or cataplexy
_____ Hypnogogic hallucinations
_____ Early AM awakening
_____ Shift worker/irregular sleep hours
_____ Difficulty initiating sleep

Risk Factors/Comorbidities:

_____ Chronic pulmonary disease
_____ CHF
_____ Diabetes
_____ Myocardial infarction
_____ Stroke
_____ Neuromuscular disease

Contraindications to HST (for diagnostic studies):

_____ Comorbid sleep disorder suspected (specify below)
PLMD CSA OHS Other: _____
_____ Patient lacks mobility/dexterity to use HST safely
_____ Patient is less than 18 years of age
_____ Patient has cognitive impairment
_____ Oxygen dependent

Contraindications to APAP (for titration studies):

_____ Co-morbid sleep disorder diagnosed (specify below)
PLMD CSA OHS Other: _____
_____ Co-morbid condition (cardiac, neuromuscular, COPD, etc.)
_____ Patient needs bi-level PAP
_____ Patient needs ASV
_____ On APAP with persistent symptoms
_____ Other: _____

Service/Test(s) Requested:

_____ ***Consult with Sleep Specialist (Sleep Specialist to order & manage study results & treatment options)***
_____ Polysomnography - PSG (diagnostic study - 95810)
_____ CPAP Titration (treatment study - 95811)
_____ Bi-level Titration (treatment study – 95811)
_____ Split night (PSG w/CPAP as indicated - 95811)
_____ ASV Titration (complex OSA treatment study - 95811)
_____ MSLT (diagnostic study for Narcolepsy, Hypersomnia - 95805)
****Must have PSG previous night for accuracy*
_____ MWT (maintenance of wakefulness test - 95805)
_____ Home Sleep Study (HST) – *patient must meet clinical and insurance criteria as determined by Sleep Specialist*

****** The Sleep Center does not provide or administer sleep medication. The ordering physician must supply the patient with a prescription for the medication, if needed. The patient must fill their prescription at a pharmacy prior to arriving at the Sleep Center. The Technologist will inform the patient of the appropriate time to take their sleep medication. ******

Follow-up Options: *(A copy of all results will be faxed to the referring physician)*

_____ Referring doctor will manage study results & treatment options *(If not checked, patient will be scheduled for a consult with a Sleep Specialist)*

Signature: _____ Date: _____ Print Physician Name: _____

Physician Phone: _____ Physician Fax: _____