ORDER FORM

Consult ***or*** Sleep Study

Phone 701.356.3000

Fax 701.271.9260

DEMOGRAPHIC INFORMATION ☐ Please attach copy of Insurance Card or Demographic Print-out

Name: _____ Home Phone: _____

Address: _____ Work/Cell Phone: _____

City/State/Zip: _____ DOB: _____

Age: _____ Height: _____ Weight: _____ Gender: M *or* F

PHYSICIAN INFORMATION

Requesting Healthcare Provider: _____ Phone: _____ Fax: _____

Primary Healthcare Provider: _____ Phone: _____ Fax: _____

Sleep History –Indications for polysomnography

- ☐ Excessive Daytime Sleepiness
- ☐ Snoring
- ☐ Witnessed Apneas
- ☐ Abnormal behavior during sleep (walking, talking, jerks…)
- ☐ Documented hypertension OR ischemic heart disease
- ☐ OTHER (Type II Diabetes, BMI ≥ 33, Atrial Fibrillation, CAD, CHF, or Depression) *Patient must meet 2 of the above criteria when choosing OTHER as option.*

A. POLYSOMNOGRAPHY STUDY TYPE:

- ☐ Standard Split-night PSG
- ☐ Standard Split-night PSG with automatic Titration (2nd study) if indicated per Interpretation
- ☐ Titration
- ☐ PSG with MSLT *(if AHI or RDI < 5)*
- ☐ MWT
- ☐ Seizure Protocol

B. PRESCRIPTION FOR CPAP/BIPAP TREATMENT:

- ☐ CPAP/BIPAP Treatment: Follow recommendations from PSG results. Utilize the DME Company chosen by the patient.

C. CONSULTATION WITH *CENTER FOR SLEEP* BOARD CERTIFIED SLEEP PHYSICIAN**:**

- ☐ A consultation ensures your patient will be evaluated by a Board Certified Sleep Physician. Our physician will manage your patient's sleep disorder for the duration of their treatment including all follow-up care.

Ordering Healthcare Provider: _____ **NPI #:** _____ **Date**: _____

Fax to (701) 271-9260: Please include clinic consult notes, patient demographic information, and insurance information.

FOR OFFICE USE ONLY

- ☐ Approval
- ☐ Denial & Reason: _____

Chief Medical Officer Signature: _____ **Date**: _____