MEMORIAL HERMANN

Sleep Disorders Center Order Form

The Medical Center	Northeast	The Woodlands	TIRR
P 713.704.2337	P 281.540.6461	P 713.897.2608	P 713.797.7742
F 713.704.5586	F 281.540.7136	F 713.897.5556	F 713.704.0872
Memorial City	**Sugar Land**	**Southeast**	**Katy Rehab**
P 713.932.5690	P 281.725.5930	P 281.929.4780	P 281.579.5680
F 713.242.4448	F 281.725.5935	F 281.929.4772	F 281.398.3932

PATIENT INFORMATION

Name: _____ Date: _____

Phone: (Home) _____ (Cell) _____ (Work) _____ Gender: ☐M ☐F

DOB: _____ Email: _____

PROCEDURES & SCREENING

REQUESTED PROCEDURE(S)

- ☐ **Diagnostic Polysomnogram** (Sleep Study)
- ☐ **CPAP Titration** (If polysomnogram is positive for OSA or a previous study was performed and results are available.)
- ☐ **Split Night Study** (Treatment portion to be performed **only if** the patient meets criteria)
- ☐ **Multiple Sleep Latency Test (MSLT)** following a Diagnostic Polysomnogram.
- ☐ **Maintenance of Wakefulness Test (MWT)**
- ☐ Portable Home Sleep Test
- ☐ **Other** _____

DIAGNOSIS

Must indicate at least one qualifying diagnosis:

- ☐ Obstructive Sleep Apnea
- ☐ Sleep Apnea, unspecified
- ☐ Parasomnias
- ☐ Hypersomnia/ EDS
- ☐ Obesity Hypoventilation Syndrome
- ☐ Disruption of Sleep/Wake Cycle
- ☐ Narcolepsy
- ☐ Sleep Related Movement Disorders
- ☐ Other Qualifying Code: _____

PRE-SCREENING

- ☐ Ht: _____ Wt: _____
- ☐ Epworth Sleepiness Scale _____
- ☐ Stop Bang Score _____
- ☐ Loud Snoring
- ☐ Witnessed Apnea
- ☐ Wakes Unrefreshed
- ☐ Daytime Sleepiness
- ☐ Frequently Waking Up
- ☐ Difficulty Falling Asleep
- ☐ Morning Headache
- ☐ Respiratory Failure, COPD, Asthma
- ☐ Depression/Anxiety
- ☐ ALS, Alzeimer's, Parkinson's, history of Stroke, Seizures, etc.
- ☐ CHF, Atrial Fibrillation, Pulmonary Hypertension, Pacemaker, Arrhythmias

ADDITIONAL INSTRUCTIONS

- ☐ **Provide full service (follow up by a Board Certified Physician and ordering CPAP/BiLevel Positive Airway Pressure with compliance monitoring if indicated and provide me with a report.)**
- ☐ **Perform requested testing only and provide with a report.**
- ☐ **Other:** _____

PHYSICIAN INFORMATION

By signing this document you are stating that a physician has completed a face-to-face clinical evaluation and has documented the patient's sleep complaint.

_____	_____	_____	_____	_____ ☐ AM ☐ PM	_____
Provider Signature	**Print Name**	**NPI/MHHS ID.**	**Date**	**Time**	**Contact No.**

**** With this order, please include: Patient demographics and insurance information, face-to-face clinic notes documenting sleep issues, and any available previous sleep studies.**

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