True Sleep Diagnostics
Better Sleep is a Better You

Phone: 864-315-0928
Fax: 864-752-6495

Sleep Study Ordering

Order must be received with patient insurance information and office visit notes containing one or more the following signs or symptoms:

a. Daytime somnolence (excessive daytime sleepiness)
    i. Have patient complete Epworth Sleepiness Scale (below)
b. Snoring
c. Observed apneas
d. Choking or gasping during sleep
e. Morning headaches

Results will be faxed to number listed on order form

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Patient Information

Name:_____ DOB:_____/_____/_____ Date:_____/_____/_____

Phone:_____ Cell:_____ Email:_____ ☐ M ☐ F

Address:_____ City:_____ St:____ Zip:_____

Primary Insurance:_____ Height:_____ Weight:_____

Referring Physician Information

Referring Physician:_____ Office Contact: _____

Address:_____ City:_____ St:_____ Zip:_____

Phone:_____ Fax:_____ NPI#:_____

Check the symptoms that best describe the patient's sleep complaint

- ☐ Loud Snoring/Disrupted Sleep
- ☐ Witnessed Apnea
- ☐ Nocturnal Choking/Gasping
- ☐ Daytime Hypersomnolence
- ☐ Non-Refreshing Sleep
- ☐ Drowsy Driving
- ☐ Morning Headaches
- ☐ Sleep Paralysis
- ☐ Leg Jerks or Restless Legs

Medical History. Please also attach medical documentation/progress notes regarding testing for OSA

- ☐ Hypertension
- ☐ Congestive Heart Failure
- ☐ Atrial Fibrillation/SVT
- ☐ Neuromuscular Impairment
- ☐ Obesity
- ☐ Diabetes
- ☐ Parkinson's Disease
- ☐ Acute Epilepsy
- ☐ History of Stroke
- ☐ Cognitive Impairment
- ☐ Previously diagnosed with OSA
- ☐ Neck Size:_____
- ☐ COPD
- ☐ Asthma
- ☐ Pulmonary Hypertension
- ☐ Oxygen Dependent LPM:_____
- ☐ Epworth:_____

Physician Order

☐ **Home Sleep Test**

I certify: That this service is medically necessary. The information provided is true, accurate and documented in the patient's clinical notes.

Physician Signature:_____ Date:_____

Fax this order, notes from office visit, and insurance information to: 864-752-6495

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Epworth Sleepiness Scale

Name: _____ Today's date: _____

Age: _____ Height: _____ Weight: _____ Sex: _____

The Epworth Sleepiness Scale is widely used in the field of sleep medicine as a subjective measure of a patient's sleepiness. The test is a list of eight situations in which you rate your tendency to become sleepy. Your total score is based on a scale of 0 to 24. The scale estimates whether you are experiencing excessive sleepiness that possibly requires medical attention. Scores > 10 warrant excessive daytime sleepiness.

How Sleepy Are You?

How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired. Even if you have not done some of these things recently try to determine how they would have affected you. For each situation, decide whether or not you would have:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

It is important that you answer each question as best you can.

Situation	Chance of Dozing (0-3)
Sitting and reading _____	___
Watching TV _____	___
Sitting, inactive in a public place (e.g. a theatre or a meeting) ____	___
As a passenger in a car for an hour without a break ____	___
Lying down to rest in the afternoon when circumstances permit ___	___
Sitting and talking to someone _____	___
Sitting quietly after a lunch without alcohol _____	___
In a car, while stopped for a few minutes in the traffic _____	

TOTAL _____