

Phone: 864-315-0928

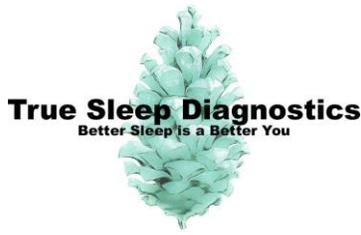
Fax: 864-752-6495

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

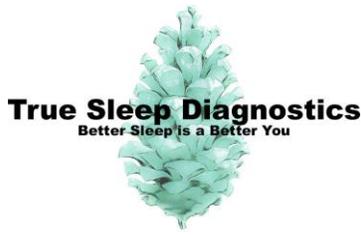
- Hypertension
- Congestive Heart Failure
- Atrial Fibrillation/SVT
- Neuromuscular Impairment
- Obesity
- Diabetes
- Parkinson's Disease
- Acute Epilepsy
- History of Stroke
- Cognitive Impairment
- Previously diagnosed with OSA
- Neck Size: _____
- COPD
- Asthma
- Pulmonary Hypertension
- Oxygen Dependent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