Sleep Disorders Center
110 N. 29th Street, STE 203
Phone: (402) 644-7404 Fax: (402) 644-7424

ACCREDITED MEMBER CENTER

PHYSICIAN DIRECT REFERRAL FORM FOR HOME SLEEP APNEA TESTING (HSAT)

Ordering Physician:	Office Phone:	Order Date:

PATIENT INFORMATION

Name:	DOB:
Best Contact Phone Number:	MRN:

PATIENT SYMPTOMS

[ ] Snoring	[ ] OSA associated medical problems (HTN/CAD/CHF, etc)
[ ] Excessive Sleepiness / Epworth Sleepiness Scale =	[ ] STOP BANG Positive
[ ] Observed Sleep Apneas	[ ] Overnight oximetry showing desaturation (please include in fax)
[ ] Obesity	[ ] Other: _____

Is Your Patient/Does Your Patient Have

[ ] A shift worker	[ ] Complaining of Insomnia (without concerns of OSA)
[ ] Restless Legs Syndrome (without concerns of OSA)	[ ] On stimulant medication (e.g. Provigil, Ritalin, etc)

[ ] Under the age of 30, without obesity or apneas, yet complaining of excessive sleepiness despite adequate total time of sleep

IF ANY OF THE ABOVE BOXES ARE CHECKED, OR IF YOUR PATIENT HAS ANY OF THE EXCLUSION CRITERIA FOR COMORBID MEDICAL OR SLEEP DISORDERS: DIRECT REFERRAL FOR A SLEEP STUDY IS NOT RECOMMENDED. THE RESULTS MAY BE INVALID. THE PATIENT SHOULD BE SEEN BY ONE OF OUR SLEEP PHYSICIANS FIRST TO ENSURE THE APPROPRIATE TEST IS ORDERED. Please call the Sleep Clinic at (402) 844-8190 to arrange a sleep consultation.

EXCLUSION CRITERIA

Comorbid Medical Disorders	*Comorbid Sleep Disorders*
• Chronic Obstructive Pulmonary Disease (COPD) • Moderate to severe Pulmonary Disease • Congestive Heart Failure (CHF) • Unstable Coronary Artery Disease (CAD) • Cardiac Arrhythmias • Uncontrolled Diabetes • Neuromuscular Disease	• Hypoxia • Hypoventilation Syndromes • Parasomnias (REM and non-REM) • Periodic Limb Movement Disorder (PLMD) • Central Sleep Apnea • Insomnia • Circadian Rhythm Disorders • Narcolepsy

SERVICE REQUESTED

[ ] Home Sleep Study: Direct Referral – Follow-up appointments and management of sleep disorder(s) are the responsibility of the ordering physician.

[ ] Home Sleep Study: Post-Referral – Follow-up and sub-sequential care/treatment requested at sleep clinic

[ ] Sleep Medicine Consultation – The patient will be seen by the physician and appropriate testing will be ordered based upon the consultation

PLEASE FAX THIS FORM TO: (402) 644-7424 PRIOR to scheduling the patients sleep study.

Please include all of the following: Office H&P and Progress Notes Completed sleep questionnaire with Epworth sleepiness scale and STOP BANG. Copy of patient demographics Copy of Insurance/Medicare/Medicaid cards and Preauthorization letter from the insurance company Signed and dated OP order with diagnosis

INSURANCE: _____ PREAUTHORIZATION: _____
DATE/DATES OF SERVICE _____

Physician Signature:	Date:

FAITH REGIONAL HEALTH SERVICES
SLEEP DISORDERS PHYSICIAN ORDER

PO0005 08.17

PATIENT STICKER