



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



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		
<input type="checkbox"/> Snoring	<input type="checkbox"/> OSA associated medical problems (HTN/CAD/CHF, etc)	
<input type="checkbox"/> Excessive Sleepiness / Epworth Sleepiness Scale =	<input type="checkbox"/> STOP BANG Positive	
<input type="checkbox"/> Observed Sleep Apneas	<input type="checkbox"/> Overnight oximetry showing desaturation (please include in fax)	
<input type="checkbox"/> Obesity	<input type="checkbox"/> Other: _____	
Is Your Patient/Does Your Patient Have		
<input type="checkbox"/> A shift worker	<input type="checkbox"/> Complaining of Insomnia (without concerns of OSA)	
<input type="checkbox"/> Restless Legs Syndrome (without concerns of OSA)	<input type="checkbox"/> On stimulant medication (e.g. Provigil, Ritalin, etc)	
<input type="checkbox"/> Under the age of 30, without obesity or apneas, yet complaining of excessive sleepiness despite adequate total time of sleep		
<p>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.</p>		
EXCLUSION CRITERIA		
<i>Comorbid Medical Disorders</i> <ul style="list-style-type: none"> • 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 	<i>Comorbid Sleep Disorders</i> <ul style="list-style-type: none"> • Hypoxia • Hypoventilation Syndromes • Parasomnias (REM and non-REM) • Periodic Limb Movement Disorder (PLMD) • Central Sleep Apnea • Insomnia • Circadian Rhythm Disorders • Narcolepsy 	
SERVICE REQUESTED		
<input type="checkbox"/> Home Sleep Apnea Test (HSAT) – follow up appointment within 90 days in sleep clinic		
<input type="checkbox"/> 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: 1. Office H&P and Progress Notes 2. Completed sleep questionnaire with Epworth sleepiness scale and STOP BANG. 3. Copy of patient demographics 4. Copy of Insurance/Medicare/Medicaid cards and Preauthorization letter from the insurance company 5. 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 05.16

PATIENT STICKER