



**Sleep Disorders Center**

110 N. 29<sup>th</sup> Street, STE 203

Phone: (402) 644-7404

Fax: (402) 644-7424

**PHYSICIAN DIRECT REFERRAL FORM FOR IN-LAB SLEEP TESTING**

Ordering Physician:	Office Phone:	Order Date:
<b>Patient Information</b>		
Name:		DOB:
Best Contact Phone Number:		MRN:
<b>Patient Symptoms</b>		
<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"/> Pre-operative screening for OSA	
<input type="checkbox"/> Observed Apneas	<input type="checkbox"/> Overnight oximetry showing desaturation	
<input type="checkbox"/> Obesity	<input type="checkbox"/> _____	
<b>Is Your Patient/Does Your Patient Have</b>		
<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 sleep time		
<p><b>IF ANY OF THE ABOVE BOXES ARE CHECKED, 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.</b></p>		
<b>Service Requested</b>		
<input type="checkbox"/> Overnight sleep study (PSG)/CPAP Titration Study: Direct Referral - follow-up appointments and management of sleep disorder(s) are the responsibility of the ordering physician.		
<input type="checkbox"/> Overnight Sleep Study (PSG)/CPAP Titration Study: Post Referral - Follow-up and sub-sequential care/treatment requested at sleep clinic.		
<input type="checkbox"/> Sleep Medicine Consultation: The patient will be seen by the physician and appropriate testing will be ordered based on consultation.		
<p><b>Please fax this form to (402) 644-7424 prior to scheduling the patient's sleep study and include:</b></p> <ul style="list-style-type: none"> <li>• Written order for the Sleep Apnea Testing with appropriate indications</li> <li>• Direct Sleep Apnea Testing Referral Form</li> <li>• Patient history and most recent physical (include height, weight and neck circumference)</li> <li>• Current list of medications and allergies</li> <li>• Sleep history, including the Epworth Scale and the Stop Bang Questionnaire</li> <li>• Patient demographics, including emergency contacts and copies of insurance or Medicare/Medicaid cards</li> <li>• Prior authorization number and copy of approval letter from insurance provider</li> </ul>		
Physician Signature:		Date: