Sleep Disorders Center
110 N. 29th 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:

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 =	[ ] Pre-operative screening for OSA
[ ] Observed Sleep Apneas	[ ] Overnight oximetry showing desaturation
[ ] 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 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.

SERVICE REQUESTED

[ ] 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

[ ] Overnight Sleep Study (PSG)/CPAP Titration Study: Post Referral – Follow-up and sub-sequential care/treatment requested at sleep clinic

FAITH REGIONAL HEALTH SERVICES
PHYSICIAN ORDER IN-LAB SLEEP TESTING

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PATIENT STICKER

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

PLEASE FAX THIS FORM TO: (402) 644-7424 prior to scheduling the patients sleep study and include:

- Written order for the Sleep Apnea Testing with appropriate indications/reason for testing
- Direct Sleep Apnea Testing Referral Form
- Patient history and most recent physical (include height, weight and neck circumference)
- Current list of medication and allergies
- Sleep history, including the Epworth Scale and the Stop Bang Questionnaire
- Patient demographics, including emergency contacts and copies of insurance or Medicare/Medicaid cards • Prior authorization number copy of approval letter from insurance provider

Physician Signature:	Date: Time: