SLEEP CENTER **ORDER FORM**

FAX TO: **503-935-8070**

THE OREGON CLINIC

PATIENT LAST NAME	FIRST	M	
PATIENT MAIN PHONE ( ) -	ALTERNATE PHONE ( ) -		DATE OF BIRTH / /
ADDRESS	CITY	STATE	ZIP
INSURANCE	INSURANCE AUTHORIZATION #		DATE RANGE / /

Please attach a copy of insurance card, demographic information, history and physical, chart notes with indication for sleep study, problem list, medication list and significant allergies.

INDICATIONS FOR SLEEP STUDY

- ☐ Sleep apnea
- ☐ Snoring
- ☐ Hypercapnia/hypoventilation
- ☐ Abnormal movements
- ☐ Narcolepsy
- ☐ Observed apnea
- ☐ Bariatric surgery
- ☐ CHF/CAD
- ☐ REM behavior disorder
- ☐ Seizures
- ☐ Complex sleep apnea
- ☐ Pulmonary hypertension
- ☐ Cardiac arrhythmia
- ☐ Bruxism
- ☐ Diabetes
- ☐ Excessive daytime sleepiness
- ☐ Hypertension
- ☐ Parasomnia
- ☐ RLS/PLMD
- ☐ Other *(please specify)*:

SLEEP STUDY REFERRAL

The ordering provider is responsible for discussing test results with patient and initiating treatment, if indicated.

- ☐ Split-night study — Diagnostic + CPAP/bilevel titration if The Oregon Clinic Sleep Center criteria are met
- ☐ CPAP/bilevel titration — Must provide prior sleep study
- ☐ Home sleep apnea test — *A response to all the questions below is **required**. If any answer is yes, please order a referral to a sleep provider instead.*

◯ Yes	◯ No	Does patient have moderate to severe COPD?
◯ Yes	◯ No	Does patient have moderate to severe CHF?
◯ Yes	◯ No	Does patient have a concern for central apnea, i.e., is patient on opiate narcotics?
◯ Yes	◯ No	Does patient have neuromuscular disease?
◯ Yes	◯ No	Does patient have cognitive or mobility issues that would make using testing equipment difficult?
◯ Yes	◯ No	Does patient use home oxygen?
◯ Yes	◯ No	Has patient had a CVA within 30 days?
◯ Yes	◯ No	Is there concern for other sleep disorders besides OSA?

◯ Yes ◯ No Would you like a sleep medicine referral that includes consultation, follow up, and prescription for PAP if indicated?

REFERRING PHYSICIAN	PHONE	FAX
	( ) -	( ) -
ADDRESS	CITY	STATE ZIP
PHYSICIAN SIGNATURE		DATE
		/ /

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