

SLEEP CENTER ORDER FORM

FAX TO: 503-963-3140



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	Observed apnea	Complex sleep apnea	Excessive daytime sleepiness
Snoring	Bariatric surgery	Pulmonary hypertension	Hypertension
Hypercapnia/hypoventilation	CHF/CAD	Cardiac arrhythmia	Parasomnia
Abnormal movements	REM behavior disorder	Bruxism	RLS/PLMD
Narcolepsy	Seizures	Diabetes	
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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