

Alamo Sleep Disorders Center

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www.AlamoSleep.com

Physician's Order for Sleep Study

Patient Name: _____ DOB: _____ Ins: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Service Requested (Please Check):

- Refer to Sleep Specialist at Alamo Sleep Disorders Center, Inc.
- Standard evaluation (1-2 nights of polysomnography) for possible obstructive sleep apnea (OSA).
If the Apnea + Hypopnea Index (AHI) is greater than 15/hour in the first two hours of recording, a titration trial of CPAP will be initiated. If the baseline sleep study demonstrated significant sleep apnea (AHI>5 hour) but the patient does not qualify for CPAP after two hours, the patient will be scheduled for a second sleep study for a full night of CPAP titration.
 - Treatment follow-up with Sleep Specialist
- Baseline without any CPAP intervention
- CPAP titration study (for patients with documented OSA by previous sleep study).
- BIPAP titration study (as indicated in previous sleep study)
- Resmed Adapt SV titration study (as indicated in previous sleep study)
- Multiple Sleep Latency Test (MSLT) with a baseline study the night before
- Daytime Desensitization Training
- Consider sedative hypnotic such as zolpidem to aid in patient's sleep (your physician will need to prescribe if needed)
- Neurological consult
 - Vascular
 - Headache
 - Epilepsy
 - Other (Please specify) _____

Brief History : _____

Check If Present:

- 1) Respiratory Dysfunction
 - Witnessed apneas Audible snoring Morning headaches
- 2) Sleep Disturbance
 - Abnormal movements during sleep Three or more awakenings per night
- 3) Daytime Somnolence
 - Mild (sleepy during the day but does not sleep inappropriately)
 - Moderate (naps if possible; falls asleep sitting up if permitted)
 - Severe (requires naps; falls asleep while driving)
- 4) Relevant History:

<input type="checkbox"/> OSA	<input type="checkbox"/> Home Oxygen	<input type="checkbox"/> Overweight (BMI>27<30)	<input type="checkbox"/> UPPP
<input type="checkbox"/> COPD	<input type="checkbox"/> CPAP	<input type="checkbox"/> Tonsillectomy	<input type="checkbox"/> CAD
<input type="checkbox"/> CHF	<input type="checkbox"/> BIPAP	<input type="checkbox"/> Tracheotomy	<input type="checkbox"/> CVA
<input type="checkbox"/> Depression	<input type="checkbox"/> Nocturia	<input type="checkbox"/> Obesity (BMI>30)	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Upper Airway Resistance Syndrome	<input type="checkbox"/> Other:		

Physician Information:

Physician's Signature: _____ **Date:** _____
(SIGNATURE STAMPS NO LONGER ACCEPTED PER CMS EFFECTIVE 02/01/09)

Ordering Physician: _____ NPI: _____ Phone #: _____ Fax #: _____

Address: _____ City/St/Zip: _____