Sleep and Fatigue Treatment Center — Sleep Data USA Sleep Disorder Center

Sleep well. Awake refreshed.

Requisition for Sleep Studies & Consultations

Request For: ☐ **Consultation & Sleep Assessment** (To be done at SFTC & SDU) ☐ **Sleep Consultation** (To be done at SFTC) ☐ **Sleep Study Only** (To be done at SDU)

Note: *Patient may be scheduled directly into the sleep lab at the discretion of the medical director.

Patient: _____ D.O.B: _____S.S#_____-_____-_____

Home #: _____ Cell #: _____

Address:_____

City: _____ State: _____Zip Code: _____

Home Phone: _____ Cell Phone: _____

Primary Insurance: _____Secondary Insurance: _____

Previous Sleep Study: ☐ Yes ☐ No When was last one?: _____ Pressure: _____

MEDICAL HISTORY: (PLEASE CHECK ALL THAT APPLY)

☐ CAD	☐ CVA	☐ Parkinson's	☐ GERD	☐ Panic Attacks	☐ Asthma/COPD
☐ Hypertension	☐ CHF	☐ Traumatic Brain Injury	☐ Lyme Disease	☐ PTSD	☐ Migraines/Headaches
☐ MVA Accident	☐ MI	☐ Fibromyalgia	☐ Seizures	☐ OCD	☐ Chronic Fatigue Syndrome
☐ Diabetes	☐ IBS	☐ Chronic Pain	☐ Bruxism	☐ Mood Disorder	☐ **Other:** _____

MEDICATIONS: Allergies: ☐ NKDA

_____

_____

SLEEP STUDY ORDERED:

☐ PSG	Polysomnogram. To evaluate sleep disturbances objectively.
☐ CPAP / BIPAP Titration	Titration Study. Following a PSG if patient has DX of OSA. Will order Split-Night Study as per protocol.
☐ PSG / MSLT	Polysomnogram & Daytime Sleep Study to assess daytime sleepiness: Required to DX Narcolepsy.
☐ PSG / MWT	Polysomnogram & Daytime Sleep Study to assess daytime alertness: Useful to assess alertness factor.
☐ Post Surgical or Appliance PSG	Polysomnogram completed as a f/u to ENT Surgery or to assess efficiency of oral –appliance therapy.

SLEEP SYMPTOMS: (PLEASE CHECK ALL THAT APPLY)

☐ Sleep Apnea/Breathing Pauses during sleep	☐ Loud or Disruptive Snoring	☐ Attention Issues
☐ Excessive Daytime Sleepiness (EDS)	☐ Somnolence or Drowsiness	☐ Behavioral Issues
☐ Nocturnal Awakenings/ Arousals during sleep	☐ Fatigue or Malaise	☐ Narcolepsy
☐ Chronic Insomnia	☐ Waking Up too early in the A.M.	☐ Sleep Walking/Talking
☐ Periodic Limb Movements during sleep	☐ Hot Flashes	☐ Co-Sleeping Issues
☐ Restless legs just prior to, or while falling asleep	☐ Frequent Nocturnal Urination	☐ Circadian Rhythm Disorder
☐ Difficulty Falling Asleep	☐ Shift Work Disorder	☐ Cataplexy
☐ Difficulty Staying Asleep	☐ Obesity	☐ **Other:**_____

REFERRING PHYSICIAN:

Physician Name: _____ NPI: _____

Telephone #: _____Fax #:_____

Physician Signature: _____

☐ 777 E. Atlantic Avenue, Suite 301
Delray Beach, FL 33483
Phone (561) 455-4430
Fax (561) 455-4434

☐ 8140 S.E Federal Hwy.
Hobe Sound, FL 33455
Phone (772) 781-4747
Fax (772) 781-4749

☐ **Please check box if you need more referral forms.** ☐ **Please attach a copy of patient's insurance card.**