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AASM  
ACCREDITATION

### IN-LAB SLEEP STUDY ORDER FORM

Please fax this form with a copy of insurance card and a recent office note to process scheduling.

REFERRED BY (Practice and Clinician Name): \_\_\_\_\_

OFFICE TEL: \_\_\_\_\_

OFFICE FAX: \_\_\_\_\_

ORDERING CLINICIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

REQUEST FOR (check one):  TEST ONLY  CONSULT FIRST  CONSULT ONLY IF TEST POSITIVE

#### PATIENT INFORMATION:

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Phone: \_\_\_\_\_ Address: \_\_\_\_\_

Emergency Contact Name and Relationship: \_\_\_\_\_

Emergency Contact Phone Number: \_\_\_\_\_

Gender: M / F / Non-Binary Preferred Pronoun: He / She/ They Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Habitual bedtime on weekdays \_\_\_\_\_ AM/PM

Habitual bedtime on weekends \_\_\_\_\_ AM/PM

Habitual waketime on weekdays \_\_\_\_\_ AM/PM

Habitual waketime on weekends \_\_\_\_\_ AM/PM

#### TEST REQUESTED:

PSG (OR home sleep apnea test if PSG denied)  PSG with ETCO2 (<12 years)  PSG + MSLT  MWT

CPAP Titration  Bi-Level Titration  ASV Titration  PSG with full EEG for seizure evaluation

Special needs for testing:  needs mobility assistance (a helper must be present all night);  language barrier (an interpreter must be present all night);  bedwetter; other \_\_\_\_\_

SYMPTOMS:  sleep apnea (attach prior sleep study)  snoring  witnessed apneas  daytime sleepiness

insomnia  restless sleep  parasomnias  history of seizures  concentration problems

uncontrolled HTN  weight gain \_\_\_\_\_ other: \_\_\_\_\_