Sleep Study Evaluation Form
Screening questions and neck circumference measurement to establish a need for a sleep study.

1. Have you had a sleep study in the past? Yes No
   - If yes; are you currently using CPAP at night? Yes No

A “yes” to question #1 is an **Automatic Disqualifier** for an outpatient sleep referral....**DO NOT PROCEED**

2. Neck circumference
   - Male Results: __________ (>17 inches) Yes No
   - Female Results: __________ (>16 inches) Yes No

A “yes” to question #2 is an **Automatic Qualifier** for an outpatient sleep referral......**DO NOT PROCEED**

If response to question #1 and/or #2 above is “No” please proceed with the following screen:

3. Do you have high BP? Yes No

4. Do you fall asleep during the day? Yes No

5. Has anyone ever told you that you snore when sleeping? Yes No

Note: If the patient answers yes to two of the above questions the patient is a candidate for a sleep study. Copy the Screening tool and place in the patients chart in the daily progress note section. Complete order for sleep Diagnosis and Treatment. Place this in physician order section of chart for physician signature. Bring original screen back to the department and place in the folder labeled sleep study screens.
**Order for Sleep Diagnosis and Treatment**

**Patient Information:**
Patient Name: ___________________________ DOB: ________________________
Address: ________________________________
Home Phone: (_____) - _____ - __________ Work Phone: (_____) - _____ - __________
Primary Insurance: __________________________
Secondary Insurance: ________________________

**Physician Information:**
Ordering Physician: _____________________ Primary Care Physician: ____________
Phone: (_____) ______ - ___________ Phone: (_____) ______ - ___________
Fax: (_____) ______ - ___________ Fax: (_____) ______ - ___________
Diagnosis: ____________________________________________________________________

**Orders:**

- **COMPLETE COORDINATION OF CARE:** includes initial consultation, orders for sleep tests, evaluation of results, patient follow-up and RX or referral for any treatment, including CPAP, medication, dental appliance, surgery, etc.
- **Post-Sleep Study Coordination of Care:** covers consultation after abnormal sleep study, including evaluation of sleep study results, patient follow and RX or referral for any treatment, including CPAP, medication, dental appliance, surgery, etc.
- **Polysomnogram (PSG):** this overnight stay procedure will record three channels of EEG, two channels of eye movement, one channel of chin EMG, nasal pressure transducer for airflow, tracheal microphone, chest expansion, diaphragmatic excursion, EKG, leg EMG, body position and SAO2. This is the standard test for sleep apnea, snoring, restless legs syndrome or narcolepsy.
- **Split-Night Polysomnogram:** this is a regular PSG for approximately two hours, followed by CPAP titration if the apnea hypopnea index is above 20/hour, or if desaturations are consistently below 85%. Original Split-Night order will qualify patient for PSG as well as CPAP Titration Study if patient does not qualify for CPAP initiation in initial study. This is indicated for patients with high probability of sleep apnea.
- **CPAP Titration:** full night PSG with CPAP titration. This test is indicated for patients with documented sleep apnea.
- **CPAP Set-Up:** includes lifetime (99) RX for machine, mask, cushion, headgear, tubing, filter, heated humidifier and patient care instructions with 1 week, 3 month and a 6 month follow-up.
- **Multiple Sleep Latency Test (MSLT):** attended daytime naps to investigate daytime sleepiness. A PSG is typically performed the prior night to detect disorders of sleep and to insure adequate sleep time before testing for sleepiness.

**Special Requests:**
All individual studies will be a full night study including three channels of EEG, two channels of eye movement, one channel of chin EMG, nasal pressure transducer for airflow, tracheal microphone, chest expansion, diaphragmatic excursion, EKG, leg EMG, body position and SAO2.

**Physician Preference:** (please circle) Konrad Bakker, MD. Marc Raphaelson, MD. James Yan, MD.

All reading physicians are board certified in sleep medicine. Orders without a designated physician default to Konrad Bakker, MD.

The above referred patient has an absolute medical necessity for the item(s) listed above, based on the above preliminary diagnosis. I certify that the above prescribed item(s) is/are medically indicated and, in my opinion, reasonable and necessary with reference to the standards of medical practice and treatment of this patient's condition.

**Ordering Physician's Signature:** ________________________________ Date: ____________