

Georgia Lung Associates Sleep Center
3820 Medical Park Dr, Suite 2100 Austell, GA 30106
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Physician Request for Sleep Evaluation

Patient Name: _____

Street Address: _____
Last First Middle

City/State/Zip: _____

SS#: _____ DOB: _____ Age: _____

Height: _____ Weight: _____ Collar/Neck Size _____ BP: _____

Home Telephone: _____ Work Telephone: _____

Patient Insurance Co: _____ Phone# _____

Policy ID# _____ Group# _____

Referring Physician _____ Contact _____

Phone _____ Fax _____ Date _____

Special Instructions: _____

Please check appropriate request:

Consultation w/ sleep physician Sleep study followed by evaluation by sleep physician

If ordering a sleep study please check appropriate procedure:

(95810) Polysomnogram (routine study) (95811) CPAP/BIPAP Titration
 Split Night Study (polysomnogram & CPAP titration)
 (95805) Multiple Sleep Latency Test (95805) Measure of Wakefulness Test

Descriptions of Symptoms:

Excessive sleepiness
 Snoring
 Witnessed Apnea
 Awakens un-refreshed
 AM headaches

Length of sleep complaint:

New onset
 Several months
 Years

Does the patient have trouble staying awake:

While driving? While watching TV?
 While talking to people? While sitting or performing a quiet task?

Is there any history of:

Stroke or CVA COPD/Asthma Cardiac disease
 Hypertension Diabetes Seizures

Throat Exam:

Large uvula
 Large tonsils
 Unremarkable

Is patient retrognathic:

Yes
 No

I have reviewed the above patient information provided by the requesting physician and found the history and physical as well as the procedure to be complete and in accordance with the American Academy of Sleep Medicine Accreditation standards.

Medical Director/Board Certified Sleep Physician
(Georgia Lung Associates Sleep Doctor)

Date