Georgia Lung Associates Sleep Center

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Ph:(770)819-2986 or (770)948-6041 Fax:(678)398-3388

Physician Request for Sleep Evaluation

Patient Name:____
Last First Middle

Street Address:____

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 **Date**

(Georgia Lung Associates Sleep Doctor)

GEORGIA LUNG ASSOCIATES
ADDENDUM TO SLEEP STUDY ORDER FORM
(Please check the appropriate answer)

PATIENT NAME:______________________________ PATIENT SS#:_________________________

	YES	NO
Is patient on oxygen? **(If yes, how many liters? ________)**	☐	☐
Do you prefer oxygen be removed during study?	☐	☐
Is patient alert and oriented?	☐	☐
Is patient ambulatory?	☐	☐
Is patient confined to a wheelchair?	☐	☐
Is patient incontinent?	☐	☐
Will patient require assistance for the bathroom?	☐	☐
Does patient have any chronic condition that would affect the sleep study, i.e. Parkinson's disease, ALS, MS, etc?	☐	☐
Does patient have transportation to and from sleep study?	☐	☐
Will patient require a caregiver during the study?	☐	☐