Parkland Medical Center
Center for Sleep
One Parkland Drive, Derry, NH 03038

REQUEST FOR SERVICES

FAX TO 603.421.2293 with most recent H&P.
The patient will be contacted for scheduling.

SLEEP SPECIALIST CONSULT REQUESTED:

☐ **YES** Consulting Physician manages care including CPAP set-up, if appropriate
☐ **NO** Referring Physician orders all services including CPAP set-up, if appropriate. (*CPAP ExpressCare* SM option available below)

Please choose the interpreting physician for your patient's study:
☐ I. Kogan, M.D. ☐ J. Rind, M.D. ☐ G. Smull, M.D. ☐ G. Neal, M.D. ☐ No Preference (fastest turn around)

Patient Name ____________________ D.O.B. _____/_____/_____ Height______ Wt______lbs.

Patient Phone Numbers: (_______)__________________ Home (________) ______________________ Alternate

Usual Workday Bedtime ____________AM/PM Usual Non-Workday Bedtime ___________ AM/PM

STUDY REQUESTED (Order Required to Schedule Study):

☐ Screening Sleep Study	All night diagnostic PSG. CPAP will not be applied unless severe apnea is present.
☐ Standard Sleep Study (Split)	Diagnostic testing which will include CPAP initiation and titration if appropriate clinical criteria are met. *If criteria are met too late to initiate treatment, patient will be scheduled for a subsequent CPAP titration night.*
☐ All Night PAP Titration	**OSA or UARS must already be PSG-documented. Date of previous PSG:_____/_____/_____** Positive airway pressure will be titrated to optimal pressure level. ___ CPAP ___ BiPAP * ___ ASV * *** CPAP must be previously proven ineffective**
☐ Narcolepsy Study	All night sleep study with next day MSLT (Multiple Sleep Latency Test) *Includes routine urine drug toxicology screen*

CPAP EXPRESSCare SM
☐ **CPAP ORDER**

I authorize the Center for Sleep at Parkland Medical Center to coordinate home PAP therapy the morning following the study through a participating DME vendor. Patient will be set up on auto titrating device with a setting of 6cm H2O to increase 3cm H2O above optimal pressure with heated humidifier. Definitive optimal pressure to be defined by interpreting Physician upon formal interpretation. Overnight oximetry to be performed to assess oxygenation 1 week following set up of CPAP for patient with severe OSA or hypoxia. ***BIPAP and ASV titrations will require a separate script which will be sent the morning following testing.***

INDICATIONS FOR SLEEP STUDY (Required to demonstrate Medical Necessity):

☐ Obstructive Sleep Apnea (327.23)	☐ Central Apnea (327.21)	☐ Narcolepsy (347.00)	☐ Phase Delay (327.31)
☐ Periodic Limb Movement Disorder (327.51)	☐ Unspecified Sleep Apnea (780.57) *	☐ Parasomnias (327.40)	☐ Other:

SLEEP SYMPTOMS / HISTORY (Please Check Appropriate Boxes)

☐ Excessive Daytime Sleepiness *	☐ Weight Loss/Gain (to ascertain optimal PAP)	☐ Nightmares or Night Terrors	☐ Insomnia / Fragmented Sleep
☐ Snoring *	☐ Bruxism /Teeth Grinding	☐ Cataplexy	☐ Leg Cramps, Movement or Jerks
☐ Witnessed Apneas *	☐ Sleep Paralysis	☐ Insufficient response to PAP	☐ Morning Headaches
☐ Overweight (BMI: ________)		☐ REM Behavior Disorder	☐ Sleep Walking or Talking

MEDICAL HISTORY (Please Check Appropriate Boxes)

☐ Seizures	☐ Impaired Cognition	☐ Anxiety *	☐ CHF	☐ COPD
☐ Sinusitis / Rhinitis	☐ Mood Disorders	☐ Heart Disease	☐ Stroke	☐ Depression
☐ Allergies	☐ Diabetes	☐ Hypertension	☐ Atrial Fibrillation	☐ Other:

*** If your patient may be claustrophobic, consider prescribing a short-acting anxiolytic (e.g.; 0.5 to 1 mg. of lorazepam) for the patient to self-administer in the lab. If medication that may cause sedation is prescribed, advise the patient NOT to drive at the completion of the test.**

SPECIAL NEEDS / ASSISTANCE REQUIRED: ☐ Mobility ☐ ADL's ☐ Cognitive ☐ Behavioral ☐ Safety ☐ Other:

Oxygen: ____L/min. ____ Nocturnal _____Dental Appliance _____ S/P; Upper Airway Surgery

☐ CPAP Compliance Problems ☐ Behavioral Health Issues that may affect study (specify):	☐ Walker, Wheelchair, Assistance Walking ☐ Incontinence Problems ☐ Interpreter – Language:
Allergies: ☐ Tape ☐ Latex ☐ Talc ☐ Medication or Environmental Allergy: _________________	Current Medications: *In the lab, oral & injectable medications can only be self-administered by the patient.*

I authorize the Center for Sleep at Parkland Medical Center to conduct the above named study.

Requesting Physician:______________________ **NPI:** ____________________**(REQUIRED) Date**: ____/____/____ **(REQUIRED)**

Signature:____________________ **(REQUIRED) (Must be enrolled with Medicare to order services for Medicare patients) Phone:**______________