Sleep Disorders Institute MW

Phone: (913) 754-3275 **Fax: (913) 754-3276**
Toll Free: (800) 403-6483 **Fax: (888) 403-6483**
• Overland Park KS • Leavenworth, KS • Lawrence, KS • Blue Springs, MO
Email: *sleepdisorders@kc.rr.com* • Website: *www.sleepdisordersinstitute.com*

Date of Study_____Time_____
Pt Packet Sent E M F Date_____

Patient Name:_____ DOB:_____
Address:_____City_____State_____Zip_____
Home # _____ Cell _____ Email _____
Ht: _____ Wt: _____ Sex M F
Referring Physician: _____ NPI # _____
Medical Facility _____ Referral Contact_____
Phone # _____ Fax # _____
Primary Insurance _____ ID #_____ Group # _____
Secondary Insurance _____ ID #_____ Group # _____

Please attach a copy of the front and back of insurance cards.

Epworth Scale

Use the following scale to choose the most appropriate number for each situation:
0 = no chance of dozing 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing
(*0-9 - Within Normal Range for most people. *10 Plus - Sleep Study Recommended)

SITUATION CHANCE OF DOZING	DATE _____
Sitting and reading.	0 1 2 3
Watching TV	0 1 2 3
Sitting inactive in public (movie or meeting)	0 1 2 3
As a passenger in a car for an hour, without a break	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after a lunch without alcohol	0 1 2 3
In a car, while stopped for a few minutes in traffic	0 1 2 3
Lying down to rest when circumstances permit	0 1 2 3
Total your points and enter your score	_____

_____ **Evaluate & Treat Patient as needed**

Neck Size _____Inches

Sleep Symptoms (check all that apply)

_____ Snoring _____ Fatigue _____ Witnessed Apnea _____ Sleep Walking/Talking
_____ Seizures _____ Enuresis _____ Limb Movements _____ Daytime Sleepiness
_____ Night Terrors _____ Headaches _____ Respiratory Failure _____ Fragmented Sleep
_____ Falls Asleep Driving _____ Other _____

Shift Worker? Y N **Patient's Bedtime** _____ AM/PM **Wake Up Time** _____ AM/PM

PLEASE CONFIRM THE REQUESTED PROCEDURES TO BE PERFORMED:

____ **HST** (Unattended Home Sleep Test for OSA screening - patient must qualify)
____ **Polysomnogram** (Diagnostic procedure for Sleep Apnea, PLMD, RLS, and is the base study for all CPAP titration's.)
____ **PSG/CPAP** (Split night study with diagnostic documentation and CPAP titration in one night determined by protocol)
____ **CPAP/BiPAP/ASV Titration** (Study to determine therapeutic CPAP/BiPAP treatment level. Diagnostic PSG within prior year)
____ **MWT** (Maintenance of Wakefulness Test for Sleep Latency)
____ **PSG/CPAP with MSLT** (Diagnostic PSG and MSLT to rule out narcolepsy. Two weeks of sleep logs required)
____ **Apap Trial**
____ **Durable Medical Equipment** (CPAP pressure set to cm___ level indicated by overnight CPAP Titration with heated humidification)
_____327.23 OSA _____ lenght of need (99 - lifetime)

***Please fax the completed form to the Sleep Disorders Institute at (913) 754-3276**

Physician's Signature _____ Date _____

Sleep Disorders Institute NE

Toll Free: (800) 403-6483 Fax: (888) 403-6483
8600 Rolling Road, Ste 200, Manassas VA 20110
4080 Lafayette Center Drive, Ste 230B Chantilly, Virginia 20151
Email: sleepdisorders@kc.rr.com • Website: www.sleepdisordersinstitute.com

Date of Study_____Time_____
Pt Packet Sent E M F Date_____

Patient Name:_____ DOB:_____
Address:_____City_____State_____Zip_____
Home # _____ Cell _____ Email _____
Ht: _____ Wt: _____ Sex M F
Referring Physician: _____ NPI # _____
Medical Facility _____ Referral Contact_____
Phone # _____ Fax # _____
Primary Insurance _____ ID #_____ Group # _____
Secondary Insurance _____ ID #_____ Group # _____

Please attach a copy of the front and back of insurance cards.

Epworth Scale

Use the following scale to choose the most appropriate number for each situation:
0 = no chance of dozing 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing
(*0-9 - Within Normal Range for most people. *10 Plus - Sleep Study Recommended)

SITUATION CHANCE OF DOZING	DATE _____
Sitting and reading.	0 1 2 3
Watching TV	0 1 2 3
Sitting inactive in public (movie or meeting)	0 1 2 3
As a passenger in a car for an hour, without a break	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after a lunch without alcohol	0 1 2 3
In a car, while stopped for a few minutes in traffic	0 1 2 3
Lying down to rest when circumstances permit	0 1 2 3
Total your points and enter your score	_____

_____ **Evaluate & Treat Patient as needed**

Neck Size _____Inches

Sleep Symptoms (check all that apply)

____ Snoring ____ Fatigue ____ Witnessed Apnea ____ Sleep Walking/Talking
____ Seizures ____ Enuresis ____ Limb Movements ____ Daytime Sleepiness
____ Night Terrors ____ Headaches ____ Respiratory Failure ____ Fragmented Sleep
____ Falls Asleep Driving ____ Other _____

Shift Worker? Y N **Patient's Bedtime** _____ AM/PM **Wake Up Time** _____ AM/PM

PLEASE CONFIRM THE REQUESTED PROCEDURES TO BE PERFORMED:

____ **HST** (Unattended Home Sleep Test for OSA screening - patient must qualify)
____ **Polysomnogram** (Diagnostic procedure for Sleep Apnea, PLMD, RLS, and is the base study for all CPAP titration's.)
____ **PSG/CPAP** (Split night study with diagnostic documentation and CPAP titration in one night determined by protocol)
____ **CPAP/BiPAP/ASV Titration** (Study to determine therapeutic CPAP/BiPAP treatment level. Diagnostic PSG within prior year)
____ **MWT** (Maintenance of Wakefulness Test for Sleep Latency)
____ **PSG/CPAP with MSLT** (Diagnostic PSG and MSLT to rule out narcolepsy. Two weeks of sleep logs required)
____ **Apap Trial**
____ **Durable Medical Equipment** (CPAP pressure set to cm___ level indicated by overnight CPAP Titration with heated humidification)
_____327.23 OSA _____ lenght of need (99 - lifetime)

***Please fax the completed form to the Sleep Disorders Institute at (913) 754-3276**

Physician's Signature _____ Date _____