POLYSOMNOGRAPHY ORDER FORM
Sparrow Sleep Center

PATIENT'S "FULL LEGAL" NAME ______________________ Date __________

DOB __________ Social Security # __________ Minor's parents names __________

Address __________ City __________ State __________ Zip __________

Home Phone __________ Alternative Phone __________

Family Physician: __________ Insurance/s: __________

⇨ **Patient Authorizes:** __________ (spouse, relative etc) to discuss appointment arrangement. **Patient Initials** __________
IF NOT COMPLETED, WE WILL ONLY DISCUSS ARRANGEMENTS/PROCEDURES/DIAGNOSIS WITH PATIENT/PHYSICIAN!

REASON FOR SLEEP STUDY (check at least 2 items - requirement for insurance)

- ☐ Daytime Hypersomnia
- ☐ Observed Apneas
- ☐ Loud or Irregular Snoring
- ☐ Morning Headaches
- ☐ Frequent Nocturnal Arousals
- ☐ R/O Nocturnal Low O2 Saturation
- ☐ R/O Obstructive Sleep Apnea
- ☐ R/O RLS/PLMs (kicking - jerking)
- ☐ R/O REM Behavior Disorder
- ☐ R/O Narcolepsy (cataplexy, etc)
- ☐ CPAP recheck
- ☐ BiPAP recheck
- ☐ O2 recheck
- ☐ Post-Op
- ☐ Insomnia

Check Special Needs: ☐ Hospital bed ☐ Wheelchair ☐ Walker ☐ Other __________

Patient is: ☐ Hearing impaired ☐ Vision impaired ☐ Diabetic ☐ COPD ☐ Other __________

Does Patient use O2 at home? ○ yes ○ no __________ LPM Does Patient use CPAP/BIPAP at home? ○ yes ○ no

PHYSICAL FINDINGS

Height __________ Weight __________

Temp: __________ Pulse __________ RR __________

Blood Pressure ______ / ______

Extremities __________

Heart __________

Lungs __________

CHECK WHICH AIRWAY APPLIES

☐ LG ☐ MD ☐ SM

CURRENT MEDICATIONS: **(or fax list of meds)**

__________ __________ __________

__________ __________ __________

TYPE OF TEST

- ☐ PSG: Diagnostic Sleep Study with CPAP - BiPAP - O2 titration per Sparrow Sleep Center protocol.
- ☐ 2nd Study/CPAP titration study (date & initial original faxed order, we will set-up cpap appointment with patient).

Special Instruction: __________

Physician Office Stamp

Referring Physician __________
Phone Number __________
Fax Number __________
Physician Signature __________

Physician address is necessary for copy of sleep study.

Please fax this completed form to 517-364-6315. THANK YOU!

0327-03