



Toll free 866.MY SLEEP • Fax 970.797.1345

WWW.SLEEPCENTEROTR.COM

2500 Rocky Mtn Ave Suite 310 • Loveland CO 80538

SLEEP STUDY ORDER FORM

Patient's Name _____ DOB _____ M ____ F ____
Address _____ City _____ State _____ Zip _____
Phone (H) _____ (W) _____ (Cell) _____

Insurance Information (the SleepCenter will verify coverage for you):

Primary Insurance _____ Policy # _____ Group # _____
Secondary Insurance _____ Policy # _____ Group # _____
Referring Physician _____ Office # _____

Please check symptoms that describe the patient's sleep complaint:

Checkboxes for symptoms: Loud Snoring w/ Disrupted Sleep, Witnessed Apnea, Excessive Daytime Somnolence, Nocturnal Chocking/Gasping, Drowsy Driving, Morning Headaches, Non-refreshing Sleep, Insomnia, Cataplexy, Hypnagogic Hallucinations, Sleep Paralysis, Leg jerks during sleep, Mood Disorders.
Medical History/Physician Findings: Nasal Obstruction, Large Neck Circumference, Retrognathia/Micrognathia, Crowded Oropharynx/Hypopharynx, Hypertension, CHF/A-Fib/Cardiomyopathy, COPD/Asthma, Diabetes, Last B/P, Neck Size, Epworth.

Physicians Order:

_____ PSG (Diagnostic Sleep Study)
_____ CPAP Titration Study
_____ Post Operative PSG
_____ Multiple Sleep Latency Test (MSLT preceded by PSG the prior evening)
_____ Maintenance of Wakefulness Test (MWT preceded by CPAP Titration the prior evening)
Is patient on oxygen therapy? Y / N LPM? _____ Can oxygen be added per our protocol if necessary? Y / N
Special Instructions:
Your patient will need to bring his/her own sleep aid if you would like for them to have one the night of the study.
*Office notes documenting sleep signs and symptoms mandatory for Medicare Insured.

I have referred the above patient for a medically necessary sleep diagnostic study for the reasons indicated on this form.

Please check if you would like our Interpreting Physician to follow up with and treat the patient listed above if they test positive.

Referring Physician Name _____ Office Contact _____
Phone _____ Fax _____ NPI # _____

Physician Signature _____ Date _____

Please fax this CMN, copy of patient's insurance card, office notes, and demographics to 970.797.1345