



**PROVIDENCE  
HOSPITAL**

**SLEEP DISORDERS INSTITUTE**

PROVIDENCE HOSPITAL: DePaul Building

1160 Varnum Street, NE: Suite 203

Washington, DC 20017

Tel: (202) 281 - 3232

Fax: (202) 281 - 3234

# REQUEST FOR SLEEP STUDY

## **INSTRUCTIONS TO PHYSICIAN:**

Please complete this form, and return by fax to (202) 281-3234

The Centers' Sleep Care Specialist will contact the patient to schedule tests that you have ordered.

### **PATIENT INFORMATION:**

PATIENT NAME:		DATE OF BIRTH:
PATIENT ADDRESS:		
CITY:	STATE:	ZIP:
HOME TELEPHONE:	WORK TELEPHONE:	
INSURANCE CARRIER:	ID NUMBER:	
M R #:	ACCOUNT #:	SDI IDENTIFICATION #:

### **TYPE OF VISIT REQUESTED:**

I request that the visit / procedure be determined by a board-certified physician at the Sleep Disorder Center.

Initial Consultation     
 Follow-Up Visit     
 Nocturnal Polysomnograph     
 Nasal CPAP Titration  
 Multiple Sleep Latency Test     
 Cardiac Monitoring (Holter)     
 Maintenance of Wakefulness Test (MWT)  
 Other \_\_\_\_\_

### **PATIENT REFERRED TO EVALUATE THE FOLLOWING**

Sleep Apnea     
 Restless Legs     
 Narcolepsy     
 Periodic Limb Movement Disorder  
 Insomnia     
 Daytime Sleepiness     
 Other \_\_\_\_\_

### **PATIENT HISTORY**

Snoring:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Grasping or choking during sleep:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Apneic events witnessed by partner:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Discomfort or restlessness of lower limbs before / during sleep:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Twitching, jerking, or kicking of lower limbs before or during the sleep period:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Daytime sleepiness or fatigue:	<input type="checkbox"/> YES	<input type="checkbox"/> NO

HEIGHT: _____ ft _____ in	WEIGHT: _____ lbs	B P: _____ / _____
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MEDICAL CONDITIONS:

CURRENT MEDICATIONS:

ASSISTANCE REQUIRED FOR AMBULATION, TOILETING, OR OTHER ACTIVITIES?  
 NO       YES: PLEASE EXPLAIN >>

### **REFERRING PHYSICIAN**

NAME:	TELEPHONE:	
ADDRESS:	UPN #:	
CITY:	STATE:	ZIP:
SIGNATURE:	FAX #:	E-MAIL:

## **PART OF THE MEDICAL RECORD**