Please complete all sections of this form and fax to the Sleep Lab at 402-461-5110.

Patient Name:_____ Address:_____

Date of Birth:_____ City / State / Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

ROUTINE STUDIES (*please mark the services you are requesting below*):

❑ **Home Sleep Study on room air:** *Important Notice: Patient must pick-up Home Sleep Study Equipment at Mary Lanning - equipment will NOT be sent out. At time of pick-up, patient will be given a discourse on equipment instructions and testing information (discourse time appx. 30 minutes). Assigned equipment must then be returned to Mary Lanning the next day.*

❑ **Standard Sleep Study:** Baseline sleep study with addition of CPAP / BiPAP per split night criteria if indicated.

❑ **All Night CPAP / BiPAP Titration:** Sleep study with CPAP / BiPAP treatment after positive first study (must have had first Standard Study completed.)

❑ **ASV titration:** Must have had first Standard Study completed.

SPECIALTY STUDIES: ❑ **Multiple Sleep Latency Testing:** Full night Sleep Study followed by daytime study to diagnose Narcolepsy.

Medical History: (Required - Please forward history and physical. Study cannot be scheduled until history and physical is obtained.)

❑ Excessive Daytime Sleepiness	❑ Un-refreshed Sleep	❑ Difficulty Falling Asleep	❑ Insomnia
❑ Snoring	❑ Restless Sleep	❑ Frequent Awakenings	❑ Anxiety
❑ Hypertension	❑ Congestive Heart Failure	❑ Leg Movements	❑ Seizures
❑ Witnessed Apneas	❑ Obesity	❑ Pulmonary Disease	❑ Depression

❑ Arrhythmia (Specify):_____

Suspected Sleep Disorder(s):

❑ Insomnia ❑ Narcolepsy ❑ Parasomnias / Seizures ❑ Periodic Limb Movements (PLMS) ❑ Restless Legs Syndrome (RLS)

❑ Sleep Apnea ❑ Other:_____

Sleep Epworth Score – Please rate patient's rate of dozing *(ACHC accreditation and insurance requirement)*:

0 = **No chance of dozing** **1** = **Slight chance of dozing** **2** = **Moderate chance of dozing** **3** = **High chance of dozing**

____ Sitting and Reading	____ In car stopped in traffic several minutes	____ Sitting and talking with someone
____ Siting inactive in a public place	____ As a passenger in car < 1 hour without a break	____ Watching TV
____ Sitting quietly after lunch without alcohol	____ Lying down to rest in the afternoon when time permits	

***For In-Lab Studies only*:** Is a sleep aid required to help patient properly complete sleep study? ❑ Yes ❑ No

If Yes, please select medication to be ordered:
(will be dispensed by MLH Pharmacy on night of study)

❑ Zolpidem (AMBIEN) 5 mg PO x 1 PRN sleep
❑ Eszopiclone (LUNESTA) 1 mg PO x 1 PRN sleep
❑ Eszopiclone (LUNESTA) 3 mg PO x 1 PRN sleep

Home Medications: Are home medications needed during the sleep study? ❑ Yes ❑ No **If Yes, please order the medications for self-administration below and include medication name, dosage, frequency and indication. Patient will self-administer per policy.**

_____

_____

_____

_____

_____

Physician Information:

Referring MD:_____ Phone / Fax:_____

Address:_____
City State Zip

Primary MD:_____ Phone / Fax:_____

Ordering Physician Signature_____ Date:_____ Time:_____

Mary Lanning HEALTHCARE

CP-800

Sleep Study Referral

Created: 06/09
Revised: 10/10, 12/12, 07/16, 11/17, 01/20