SLEEP CENTERS PRESCRIPTION
Complete & Fax to: 610-340-2371

☐ **Sleep Center at *Brinton Lake*** ☐ **Sleep Center at *Delaware County*** ☐ **Sleep Center at *Taylor***

DATE: _____ ***Preferred Reading Doctor (optional):*** _____

PATIENT NAME: _____ **DOB**: _____ **PHONE #**: _____

☐ **REQUEST FOR EVALUATION AND TREATMENT**
(Sleep physician will order sleep study if necessary.)

--OR--

REQUEST FOR SLEEP STUDY:

- ☐ **PSG** #95810 (baseline sleep study)
- ☐ **C-PAP** #95811 (treatment for sleep apnea)
- ☐ **MSLT** #95805 (evaluate daytime sleepiness)
- ☐ **MWT** #95805 (maintenance of wakefulness test)
- ☐ **Split** #95811 (1/2 night PSG & 1/2 night C-PAP)
- ☐ **Other** _____

WOULD YOU LIKE YOUR PATIENT TO HAVE FOLLOW-UP CARE WITH THE SLEEP PHYSICIAN?

☐ **YES** ☐ **NO**

☐ PATIENT HAS HAD PREVIOUS SLEEP STUDY
Location: _____Year: _____

☐ DESENSITIZATION TO C-PAP MASK

EVALUATE FOR:

☐ Snoring (Primary) 786.09	☐ PLMS 327.51	☐ GERD 530.81
☐ Sleep Apnea with Hypersomnia 780.53	☐ Narcolepsy 347.00	☐ HTN 401.10
☐ Restless Legs 333.94	☐ CVA 436.00	☐ Parasomnia 327.49
☐ Sleep Disruption 780.55	☐ Seizure Disorder 345.90	

PATIENT COMPLAINTS:

☐ Nocturia	☐ Non-Refreshing Sleep	☐ Nightmares
☐ Witnessed Apnea	☐ Fatigue	☐ Morning Headaches
☐ Excessive Daytime Sleepiness	☐ Memory Loss	☐ RLS
☐ Nocturnal Awakenings	☐ Concentration Difficulty	

Does patient have special sleeping needs? ☐ **No** ☐ **Yes** Explain_____
Is patient using oxygen to sleep? ☐ **No** ☐ **Yes** Flow rate is _____ L / minute_____

MEDICAL HISTORY (OR EQUIVALENT – MOST RECENT OFFICE NOTE, H & P, etc.)

Respiratory Function:	☐ Normal	☐ Abnormal	_____
Cardiac System:	☐ Normal	☐ Abnormal	_____
Mouth / Oropharynx:	☐ Normal	☐ Abnormal	_____
Abdomen:	☐ Normal	☐ Abnormal	_____

Physical Exam: B/P_____ Heart Rate_____ Weight_____ Height_____

Allergies: _____ **Latex allergy?** ☐ No ☐ Yes

Medications: _____

Past Medical History: _____

REFERRING PHYSICIAN'S SIGNATURE: _____(required)

REFERRING PHYSICIAN'S OFFICE STAMP:

History & Physical Reviewed by Sleep Physician. OK to Proceed with Planned Sleep Study.

_____ _____
Board Certified Sleep Physician Date