REQUISITION FORM

FAX: (203) 284-2839 PHONE: (203) 284-2818
sleepscheduling@gaylord.org – www.gaylordsleep.org

Gaylord Sleep Medicine
Sleep. Your life depends on it.

PATIENT INFORMATION

Name _____ DOB _____ ☐ M ☐ F

Address _____

City, State, Zip _____

Home Phone _____ Work/Cell Phone _____ Email Address _____

Primary Insurance Co. _____ ID# _____

Secondary Insurance Co. _____ ID# _____

SERVICES REQUESTED

☐ **COMPREHENSIVE SLEEP EVALUATION** → consultation with a sleep physician, testing as needed, treatment and follow-up

☐ **SLEEP STUDY AND FOLLOW UP** → includes sleep study (split night sleep study – first part diagnostic, second part CPAP titration if criteria met), post study consult and sleep apnea therapy initiation (if indicated)

☐ **SLEEP TESTING ONLY** → if medical information provided is insufficient to support need for sleep testing, or if patient is under 18 years of age, a consult will be scheduled)

- ☐ Diagnostic Sleep Study (PSG/split if lab criteria met)
- ☐ PAP Titration Study (study started with CPAP unless otherwise indicated)
- ☐ Diagnostic Sleep Study with Extended EEG
- ☐ Multiple Sleep Latency Test (preceded by PSG) for Narcolepsy (MSLT)
- ☐ Maintenance of Wakefulness Test (MWT)

☐ **SLEEP APNEA MANAGEMENT** → includes clinician visit and assessment of PAP/mask

☐ **INSOMNIA EVALUATION**

MEDICAL HISTORY (please forward most recent history and physical)

1. Sleep Symptoms (please indicate at least two)

- ☐ Snoring
- ☐ Witnessed/suspected apnea
- ☐ Restless legs syndrome (RLS)
- ☐ Abnormal leg movements in sleep
- ☐ Excessive daytime sleepiness
- ☐ Sleep maintenance insomnia
- ☐ Sleep onset insomnia
- ☐ Dream enactment behavior
- ☐ Sleep paralysis
- ☐ Sleep-related seizures
- ☐ Cataplexy
- ☐ Hypnagogic hallucinations
- ☐ Abnormal sleep-associated behaviors. Please describe: _____

2. Medical History

- ☐ Hypertension
- ☐ Diabetes mellitus
- ☐ Overweight/obesity
- ☐ Epilepsy
- ☐ Parkinson's disease
- ☐ Peripheral neuropathy
- ☐ Multiple sclerosis
- ☐ Motor neuro disease
- ☐ Myopathy
- ☐ Cerebrovascular disease
- ☐ Coronary artery disease
- ☐ Asthma
- ☐ COPD
- ☐ Congestive heart failure

3. Prior Sleep Testing

☐ No ☐ Yes If YES, was testing at Gaylord? ☐ No ☐ Yes If NO, include copy of report.

4. Physical Exam

Blood pressure _____ Height _____ Weight _____ Age _____

5. Special Needs and/or Instructions

- ☐ Wheelchair
- ☐ Hospital bed
- ☐ Ambulance assistance, specify:
- ☐ On home CPAP/BiPAP (at cm/H2O)
- ☐ On home oxygen liters/minute; start study at liters/minute
- ☐ Interpreter/language:
- ☐ Other:
- ☐ Non-standard sleep schedule, specify:

Medications (including OTC meds) _____

Allergies _____ ☐ None Med/Contact _____

REFERRING PHYSICIAN INFORMATION

NAME _____ **OFFICE PHONE** _____ **EXTENSION** _____

OFFICE ADDRESS _____ **OFFICE FAX** _____ **DATE** _____

CITY/STATE/ZIP _____ **SIGNATURE** _____