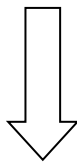




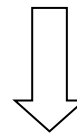
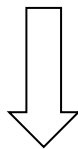
## Home Study or Clinic Study

If your pt scores a 10 or above on the Epworth sleepiness scale and have any of the following symptoms: day time sleepiness, morning headache, loud snoring. With or without the following.....



Hx of Stroke, Obesity,  
CHF, Asthma,  
Neurological  
Disorders, Atrial Fib  
and Pulmonary  
Hypertension.

No co-morbid  
medical conditions



**Please schedule:**

**In Clinic Sleep Study**

**Please schedule:**

**Home Sleep Study**

Please complete the ordering form to help us with your patient's medical history. Please contact Fitzgibbon Scheduling department 600-831-3208 to schedule in Clinic and Home Sleep studies.



**Sleep Lab**

**660.886.7431 | Ext. 3282**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Epworth: \_\_\_\_\_ Neck CX: \_\_\_\_\_ BMI: \_\_\_\_\_

**Studies Requested (Check appropriate boxes):**

- PSG in Clinic Sleep Study. (Please obtain Epworth and Neck circumference)
- PSG Home Sleep Study. (No co-morbid medical conditions)
- Split night PSG/titration of CPAP/BIPAP; (will be performed if AHI>20, or if obstructive sleep apnea becomes apparent)
- CPAP/BIPAP titration (Order if documented OSA or in combination with diagnostic PSG if high clinical suspicion of OSA)

**Symptoms/Indication (Check appropriate boxes):**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Snoring             | <input type="checkbox"/> Morning Headaches            | <input type="checkbox"/> ADHD                                   |
| <input type="checkbox"/> Witnessed Apneas    | <input type="checkbox"/> Excessive Daytime Sleepiness | <input type="checkbox"/> Periodic limb movements/jerks at night |
| <input type="checkbox"/> Frequent Awakenings | <input type="checkbox"/> Fatigue/Lack of Energy       | <input type="checkbox"/> CPAP compliance problem                |
| <input type="checkbox"/> Nocturia            |   |   |
| <input type="checkbox"/> Unrefreshing sleep  |   |   |

**Medical/Co Morbid Medical Conditions (check appropriate boxes)**

- |   |   |
|---|---|
| <input type="checkbox"/> Hypertension                             |   |
| <input type="checkbox"/> CHF                                      |   |
| <input type="checkbox"/> Arrhythmia (specify): _____              |   |
| <input type="checkbox"/> Pulmonary disease                        |   |
| __ Oxygen: ___ L/min ___ 24 hr ___ Nocturnal Use?                 |   |
| <input type="checkbox"/> Diabetes                                 | <input type="checkbox"/> Parkinson's                              |
| <input type="checkbox"/> Obesity                                  | <input type="checkbox"/> Alzheimer's                              |
| <input type="checkbox"/> Other medical disorders (specify): _____ | <input type="checkbox"/> Other medical disorders (specify): _____ |
| <input type="checkbox"/> Stroke                                   |   |

**Special Needs for Consideration during Study (check appropriate boxes):**

- |   |  |
|---|--|
| <input type="checkbox"/> Respiratory disorder | <input type="checkbox"/> Incontinence problems                   |
| <input type="checkbox"/> Supplemental oxygen  |  |
| <input type="checkbox"/> Translator           | <input type="checkbox"/> Walker, Wheelchair, assistance walking  |
| (language): _____                             | <input type="checkbox"/> Learning disability/help with paperwork |

Signature of Requesting Physician/Provider: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

To ensure optimal care, please include a copy of the office H&P or progress note detailing the reason for the visit, copy of the medication list, and authorization number. Guidelines for Home SS vary by insurance if your pt has any of the Co-Morbid condition you can still check with insurance for Authorization.

Authorization No: _____
Fax to: 660.886.3420