FITZGIBBON HOSPITAL

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.

Please schedule:

In Clinic Sleep Study

No co-morbid medical conditions

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.

FITZGIBBON HOSPITAL

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):

- ☐ Snoring
- ☐ Witnessed Apneas
- ☐ Frequent Awakenings
- ☐ Nocturia
- ☐ Unrefreshing sleep
- ☐ Morning Headaches
- ☐ Excessive Daytime Sleepiness
- ☐ Fatigue/Lack of Energy
- ☐ ADHD
- ☐ Periodic limb movements/jerks at night
- ☐ CPAP compliance problem

Medical/Co Morbid Medical Conditions (check appropriate boxes)

- ☐ Hypertension
- ☐ CHF
- ☐ Arrhythmia *(specify):*_____
- ☐ Pulmonary disease
  __ Oxygen: _____L/min ____24 hr ____ Nocturnal Use?
- ☐ Diabetes
- ☐ Obesity
- ☐ Other medical disorders (*specify):* _____
- ☐ Stroke
- ☐ Parkinson's
- ☐ Alzhelmer's
- ☐ Other medical disorders (*specify):*

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

- ☐ Respiratory disorder
- ☐ Supplemental oxygen
- ☐ Translator (language):_____
- ☐ Incontinence problems
- ☐ Walker, Wheelchair, assistance walking
- ☐ Learning disability/help with paperwork

Signature of Requesting Physican/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