Sleep Study Order Form

Phone: (512) 697-9896
Fax: (512) 697-9895
5508 Parkcrest Dr. Ste 200 Austin, TX 78731
www.thesleepcenteraustin.com

Patient Name: ________________________________ DOB: ___________ Contact Phone#:__________________

Please also provide patient's demographics, insurance information, pertinent medical history and any recent sleep studies.

SLEEP HISTORY & PRESENTING SYMPTOMS (check all that apply)

☐ Snoring
☐ Witnessed Apnea
☐ Morning Headaches
☐ Nocturia
☐ Daytime Sleepiness / Fatigue
☐ Other Symptoms:______________

☐ Nocturnal Awakenings
☐ Impaired Cognition
☐ Diabetes
☐ Insomnia
☐ Non Restorative Sleep
☐ Bruxism

☐ Restless Leg/Periodic Limb Movements
☐ Central Sleep Apnea
☐ Stroke
☐ Hypertension
☐ Obesity (BMI: __________)
☐ CHF

SERVICES REQUESTED

☐ **CONSULTATION AND MANAGEMENT**

Initial consultation with Board Certified Sleep physician followed by appropriate testing, treatment, and ongoing sleep disorder management.

☐ **SLEEP STUDY ONLY (please select study orders and diagnosis below)**

Once the study is completed, our office will send the results to the ordering physician for follow-up with the patient.

INTERPRETING PHYSICIAN: ☐ Dr. Hudson ☐ Other ______________________________
(Must be board certified in sleep)

☐ **POST TESTING CONSULT**

Review of results with the patient at a consultation appointment after the study, initiation of treatment and on-going management by a Board Certified Sleep physician.

SLEEP STUDY ORDER (1 or more may apply)

☐ **Perform HST if in-lab study is denied by insurance**
☐ NPSG – overnight sleep study
☐ HST – home sleep study (1 or 2 night)
☐ CPAP Titration Study
☐ 2-Night Sleep study (NPSG diagnostic and CPAP titration if AHI ≥ 5)
☐ Bi-level Titration only
☐ ASV Titration only
☐ MSLT – multiple sleep latency test
☐ Split Night (if AASM criteria met)
☐ Other: ____________

SUSPECTED DIAGNOSIS

☐ R/O Sleep Apnea	G47.33
☐ Treat OSA	G47.33
☐ Treat CSA	G47.31
☐ Treat Complex SA	G47.31
☐ Re-Titration for OSA	G47.33
☐ R/O PLMS	G47.61
☐ R/O Narcolepsy	G47.419
☐ Restless Leg Syndrome	G25.81
☐ Other:___________	

☐ **ARRANGE CPAP / BIPAP THERAPY**

☐ After consultation with referring physician

Referring Physician Name: __________________________ **NPI:** __________________________

Office Phone #:__________________________ **FAX:** __________________________

Physician Signature: __________________________ **Date**: __________________________

FAX RECENT CLINIC NOTE AND COMPLETED FORM TO: (512) 697-9895

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J. Douglas Hudson, M.D.