



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 CONSULT** (*Sleep physician orders sleep study after initial consultation if necessary*)
(Please include why consult is being requested under "EVALUATE FOR" section, **sign & stamp**)

- OR -

- REQUEST FOR STUDY ONLY:** (*Please check desired study*) **IF ORDERING STUDY ONLY, YOU MAY ALSO INCLUDE:**

- 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 _____
- Desensitization (to C-PAP mask)
- TREATMENT BY SLEEP PHYSICIAN**
- PATIENT HAS HAD PREVIOUS SLEEP STUDY
- LOCATION: _____ YEAR: _____

EVALUATE FOR: (*Please check appropriate diagnosis*)

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

PATIENT COMPLAINTS: (*Please check all that apply*)

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

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: _____

Medications: _____

Past Medical History: _____

REFERRING PHYSICIAN'S SIGNATURE: X _____

REFERRING PHYSICIAN'S OFFICE STAMP:

History & Physical Reviewed. OK to Proceed with Planned Sleep Study.	
_____	_____
Board Certified Sleep Physician	Date