403 Gilead Road, Suite B
Huntersville, NC 28078
(P) 704-464-1509
(F) 704-464-1393
info@ncneuro.com

RESET FORM SUBMIT FORM

SLEEP STUDY REFERRAL FORM

Referring physician (print):_____

Office Address: _____

Office Phone: _____ Office Fax: _____ Doctor's Email: _____

Physician's Signature: _____ **Date:** _____ /_____ /_____

1. Complete all information on the front of this form.
2. Complete the appropriate section on the back of this form for either an ADULT or PEDIATRIC sleep study or consultation.
3. Fax or email the completed form.

INSURANCE

Insurance Carrier: _____ Name of Insured: _____ Insurance Phone #:_____

Policy ID#: _____ Group #: _____ Insured's SS #: _____

PATIENT INFORMATION

Patient's Name: _____ Date of Birth: _____ /_____ /_____ Sex: ☐ M ☐ F

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ Patient's SS #: _____

Patient Height: _____ Patient Weight: _____

Emergency Contact Name: _____ Emergency Phone #: _____

ADULT SLEEP ORDER
PATIENT HISTORY / INDICATIONS FOR STUDY OR CONSULTATION

(Please check all that apply)

☐ Snoring
☐ Daytime sleepiness or fatigue
☐ Discomfort or restlessness of lower limbs before or during sleep
☐ Tracheostomy tube
☐ Home suctioning – trach / nasal / oral
☐ Gasping or choking during sleep
☐ Apneic events witnessed by bed partner
☐ Twitching, jerking or kicking of lower limbs before or during sleep
☐ Home oxygen use _____LPM

Medical conditions/diagnoses:

_____

_____

Please list all current medications:

Medication: _____ Dose: _____ Medication: _____ Dose: _____
Medication: _____ Dose: _____ Medication: _____ Dose: _____
Medication: _____ Dose: _____ Medication: _____ Dose: _____

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TYPE OF STUDY REQUESTED

- ☐ Consultation Only
- ☐ Nocturnal Polysomnography (NPSG)
- ☐ Split Night Study *
- ☐ Maintenance of Wakefulness Test (MWT)
- ☐ Home Sleep Testing (☐ 1 Night; ☐ 2 Nights)
- ☐ Arrange for CPAP / BiPAP equipment, if needed
- ☐ CPAP / BiPAP Titration Study
- ☐ Multiple Sleep Latency Test (MSLT)
- ☐ CPAP / BiPAP Titration Study (if indicated by the outcome of NPSG)
- ☐ Full Compliment EEG (Parasomnia/Seizure Protocol)

RULE OUT OR CONFIRM THE FOLLOWING

- ☐ Sleep Apnea
- ☐ Periodic Limb Movement Syndrome
- ☐ Daytime Sleepiness
- ☐ Insomnia
- ☐ Narcolepsy
- ☐ Other: _____

PEDIATRIC SLEEP ORDER
PATIENT HISTORY / INDICATIONS FOR STUDY OR CONSULTATION

(Please check all that apply)

- ☐ Snoring or noisy breathing
- ☐ Mouth breathing
- ☐ Neuromuscular weakness
- ☐ Restlessness
- ☐ Daytime irritability or hyperactivity
- ☐ Tracheostomy tube
- ☐ Home suctioning – trach/nasal/oral
- ☐ Gasping or choking during sleep
- ☐ Difficulty breathing
- ☐ Observed apnea
- ☐ Daytime sleepiness or fatigue
- ☐ Poor school performance
- ☐ Home oxygen use _____LPM

Has this patient had a prior study in our lab?	☐ Yes	☐ No
Is the patient on CPAP or BiPAP at home?	☐ Yes	☐ No
Does the patient have a feeding tube?	☐ Yes	☐ No
Does the patient have a neurological disorder?	☐ Yes	☐ No

Medical conditions/diagnoses:

_____

_____

Please list all current medications:

Medication: _____ Dose: _____ Medication: _____ Dose: _____
Medication: _____ Dose: _____ Medication: _____ Dose: _____
Medication: _____ Dose: _____ Medication: _____ Dose: _____

TYPE OF STUDY REQUESTED

- ☐ Consultation Only
- ☐ Nocturnal Polysomnography (NPSG)
- ☐ Split Night Study *
- ☐ Maintenance of Wakefulness Test (MWT)
- ☐ Full Compliment EEG (Parasomnia/Seizure Protocol)
- ☐ Arrange for CPAP / BiPAP equipment, if needed
- ☐ CPAP / BiPAP Titration Study
- ☐ Multiple Sleep Latency Test (MSLT)
- ☐ CPAP / BiPAP Titration Study (if indicated by the outcome of NPSG)

*Please note that the study requested can be scheduled only if the patient's demographic and medical history are accurately provided above. All medical notes are reviewed by our medical director to insure appropropriatness of study ordered. *Split night protocol studies are dependent upon the severity of the patient's sleep apnea during the first 2-3 hours of the recording.*