SLEEP STUDY ORDER FORM: *Please Attach Clinical Notes and Fax to 855-927-5566*

Doylestown Health Sleep Center
The Pavilion Suite 101, 599 W. State Street, Doylestown, PA 18901 | Tel: 800-298-3171 | Fax: 855-927-5566

Patient Name: _____ DOB: _____ Height: _____ Weight: _____ BMI: _____

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

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ ID #: _____ Group #: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Have you ever been diagnosed with Obstructive Sleep Apnea? ☐ Yes ☐ No
If yes, when _____

Are you currently using PAP therapy? ☐ Yes ☐ No
If yes, settings _____

Are you currently under the care of a Pulmonologist? ☐ Yes ☐ No
If so, physician name _____

STOP-BANG QUESTIONNAIRE

Snoring? Do you Snore Loudly (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)? ☐ Yes ☐ No

Tired? Do you often feel Tired, Fatigued, or Sleepy during the daytime (such as falling asleep during driving or talking to someone)? ☐ Yes ☐ No

Observed? Has anyone Observed you Stop Breathing or Choking/Gasping during your sleep? ☐ Yes ☐ No

Pressure? Do you have or are being treated for High Blood Pressure? ☐ Yes ☐ No

Body Mass Index more than 35 kg/m2? ☐ Yes ☐ No

Age older than 50? ☐ Yes ☐ No

Neck size large? For male, is your shirt collar 17in/43cm or larger? For female, is your shirt collar 16in/41cm or larger? ☐ Yes ☐ No

Gender=Male? ☐ Yes ☐ No

Total number answered "yes"
Total score of 3 or 4 = moderate risk of OSA | Total score of greater than 4 = high risk of OSA _____

SLEEP STUDY REFERRAL: STOP - remainder to be completed by the physician

☐ Diagnostic PSG study* (95810)
*HSAT if insurance denies in lab (95806/G0399)

☐ Home Sleep Study 95806/G0399

☐ Specialist consult pre-study**

☐ CPAP study (95811)

☐ Specialist consult post-study**

**If a referral is needed in order to schedule your patient for a post-study consultation or if your patient insurance is non-par, the Sleep Specialist will be contacting your office.

SUSPECTED DIAGNOSIS

☐ Unspecified OSA (G47.30) ☐ OSA - previously diagnosed (G47.33) ☐ Other: _____

REFERRING PHYSICIAN

Physician Name: _____ **Phone:** _____ **Fax:** _____

Address: _____ **Date:** _____ **Time** _____

Doctor Name/Signature: _____

Letter of Medical Necessity

The symptoms indicated above are consistent with the presence of a sleep disorder which could possibly be life threatening. These findings may warrant the medical necessity of an overnight polysomnographic evaluation to assess the presence and severity of a sleep disorder.