


REMY SLEEP LABS
Diagnostic Testing and Treatment for Sleep Disorders

Physician Order Form

Please fax completed form with a copy of the patients' insurance card, I.D., recent physical and clinical notes

PATIENT INFORMATION: (Please Print)

Name: _____ DOB: _____ SSN _____ - _____ - _____

Address: _____

Home Phone: () _____ Cell Phone: () _____

Email: _____

Gender: Male or Female Height _____ ft _____ in Weight _____ lbs Blood Pressure _____ / _____

Insurance: _____ ID # _____

SERVICES REQUESTED: (Please check what the patient is being referred for, select one only)

- Diagnostic Sleep Study** (Night 1) and **CPAP/BiPAP Titration Study*** (Night 2)-*Full night polysomnogram (PSG) and a full night titration for patients with documented sleep apnea*
- Split Night Study***-*Full night sleep study. First part diagnostic, second part CPAP titration, if indicated. Nasal CPAP is applied if patient meets split night criteria*
- Diagnostic Sleep Study***-*Full night polysomnogram (PSG)*
- CPAP/BiPAP Titration Study**-*Full night titration for patients with documented OSA. (Must provide prior documentation of diagnosed OSA)*
- Multiple Sleep Latency Test (MSLT)/Maintenance of Wakefulness Test (MWT)**-*Daytime nap test following a full night diagnostic PSG study to rule out narcolepsy or idiopathic hypersomnolence*
- Consultation and Management**- *Consultation with a Sleep physician to evaluate for possible sleep disorders*

* All noted studies may be followed by an MSLT (Daytime study) if deemed clinically necessary

MEDICAL HISTORY: (Please forward most recent history and physical)

Patient referred to rule out or diagnose the following:

- OSA Restless Legs Narcolepsy Insomnia Excessive Daytime Sleepiness Periodic Limb Movement
 Other _____

- Primary Symptoms:** Loud Snoring Gasping or choking during sleep Witnessed Apnea Hypertension
 Excessive Daytime Sleepiness or fatigue Obese/Large Neck Fragmented Sleep Frequent leg movements during sleep
 Difficulty falling asleep

Special Needs: Nocturnal O₂, Level _____ Interpreter, Language _____ Wheelchair Other _____

Current Medications: _____

REFERRING PHYSICIAN: (Please Print)

Name: _____ NPI: _____

Address: _____

Phone: () _____ Fax: () _____

Physician's Signature: _____ Date _____

Referral Contact Person: _____

Fax: (888) 866-1311

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