


**Fax to 603.421.2293 please include H&P
The patient will be contacted for scheduling**

Patient Name _____ D.O.B. ___/___/___ Height ___ Wt ___ lbs
 Patient Telephone Number(s) (____) _____ (home) (____) _____ (work)

SLEEP SPECIALIST CONSULT REQUESTED:
 YES Consulting Physician manages care including CPAP set-up, if appropriate
 NO Referring Physician orders all services including CPAP set-up, if appropriate. (CPAP ExpressCareSM option available below)

STUDY REQUESTED (Check Appropriate Boxes):

<input type="checkbox"/> Screening Sleep Study	All night diagnostic PSG, no treatment unless severe apnea present.
<input type="checkbox"/> Standard Split Sleep Study	Split night Will include CPAP initiation and titration if appropriate clinical criteria are met. <i>If criteria are met too late for treatment, patient will be scheduled for a subsequent CPAP titration night.</i>
<input type="checkbox"/> All Night PAP Titration	PAP titration/PSG when OSA or UARS is <u>already documented</u> . Previous study date ___/___/___ CPAP ___ Bi-Level* ___ ASV* * CPAP must be previously proven ineffective
<input type="checkbox"/> Narcolepsy Study	All night sleep study with next day MSLT (Multiple Sleep Latency Test). <i>Includes routine urine drug toxicology screen</i>
<input type="checkbox"/> 	I authorize Center for Sleep at Parkland Medical Center to coordinate home PAP therapy the morning following the study through a participating DME vendor. Patient will be set up on auto titrating device with a setting of 6 cm/H2O to increase 3cm/H2O above optimal pressure with heated humidifier. Definitive optimal pressure to be defined by interpreting Physician upon formal interpretation. Overnight oximetry to be performed to assess oxygenation 1 week following set up of CPAP for patient with severe OSA or hypoxia.

REASON FOR STUDY (Check Appropriate Boxes):

<input type="checkbox"/> Sleep Apnea/UARS	<input type="checkbox"/> Sleep-associated seizures
<input type="checkbox"/> Periodic Limb Movement Disorder/ Restless Legs Syndrome	<input type="checkbox"/> Other (specify): _____
<input type="checkbox"/> Narcolepsy	

MEDICAL/SLEEP HISTORY/SYMPTOMS (Check Appropriate Boxes):

<input type="checkbox"/> Excessive sleepiness	<input type="checkbox"/> REM Behavior Disorder
<input type="checkbox"/> Snoring	<input type="checkbox"/> Impotence
<input type="checkbox"/> Overweight	<input type="checkbox"/> Pulmonary Disease
<input type="checkbox"/> Apneas	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Insomnia	<input type="checkbox"/> CHF
<input type="checkbox"/> Nightmares	<input type="checkbox"/> Arrhythmia (specify): _____
<input type="checkbox"/> CPAP compliance problems	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Leg cramps, movements/jerks	<input type="checkbox"/> Oxygen: ___ L/min. ___ 24 hr. ___ Nocturnal
<input type="checkbox"/> Muscle / joint aches	<input type="checkbox"/> Rhinitis/sinusitis
<input type="checkbox"/> S/P UPPP; laser-assisted palatoplasty	<input type="checkbox"/> Seizures
<input type="checkbox"/> Bruxism	<input type="checkbox"/> Depression
<input type="checkbox"/> Dental appliance to advance mandible/tongue	<input type="checkbox"/> Other neurologic disorders (specify): _____
<input type="checkbox"/> Sleep walking	<input type="checkbox"/> Anxiety

SPECIAL NEEDS FOR CONSIDERATION DURING STUDY (Check Appropriate Boxes):

<input type="checkbox"/> Respiratory disorder	<input type="checkbox"/> Walker, wheelchair, assistance walking
<input type="checkbox"/> Supplemental oxygen	<input type="checkbox"/> Incontinence problems
<input type="checkbox"/> Psychiatric problems that may affect study (specify): _____	<input type="checkbox"/> Translator - Language _____
Allergies: <input type="checkbox"/> Tape <input type="checkbox"/> Latex <input type="checkbox"/> Talc	Current Medications: _____
<input type="checkbox"/> Medication or Environmental: _____	<i>In the lab, oral & injectable medications can only be self-administered by the patient.</i>

OTHER ISSUES THAT MIGHT AFFECT PATIENT COMFORT/SAFETY (specify):

Requesting Physician (Signature): _____ Tel. # (____) _____ Date ___/___/___
 Requesting Physician (Print): _____ Email: _____

DIRECTIONS

**Parkland Medical Center
One Parkland Drive
Derry, NH 03038**

From Route 93:

Take Exit 4 (102 East). Off of the exit go through 2 sets of lights. At the third set of lights, take a right on to Birch Street. PMC will be approximately 1 mile on the left.

Parking:

From the main entrance, bear to the right, down the hill towards the "Emergency Room Parking".

Once inside Parkland Medical Center:

Enter through the Emergency Department Entrance or the West/Patient Entrance and proceed to registration. Please let the registrar know that you are having a sleep study. Please remain in the waiting area for the technologist who will meet you and escort you to the sleep lab.