Physician's Order
Referral for Sleep Study

Patient Name _____ , D.O.B._____, ___M - ___F

Located at _____City _____ State ___

has been evaluated for obstructive sleep apnea and/or similar related sleep disordered breathing. A further review for sleep apnea needs to be preformed and is medically necessary based upon the following clinical conditions.

Patient history reveals the following conditions:

___ High blood pressure/hypertension

___ Depression/irritability

___ Impotency (ED)

___ Large neck 17> male, 15 ½> Fem

___ Allergic rhinitis/deviated septum

___ Type II diabetes

___ Smoking #___pack/day

___ Swelling of the feet/pedal edema

___ Obesity #____lbs overweight

___ Heart disease/ family hereditary

__Y __N

___ ft ___in Height

___ Type I diabetes

#___(daily) #___(wkly)

NOTES:

_____

_____

The patient's sleep observer witnessed the preceding sleep abnormalities:

___ Cessation of breathing

___ Arousals thru choking & gasping

___ Awakens with sore throat

___ Frequent headaches

___ Snoring/gargling during sleep

___ Daytime sleepiness/fatigue

The factors shown indicate the high probability of sleep apnea, hypoventilation, or upper airway resistance, which should be treated if diagnostically confirmed through a sleep study. If interpreting physician recommends CPAP/BiPAP therapy, then interpreting physician may order DME.

Physician Information

_____	_____	_____
Ordering Physician	Physician Lic. #	UPIN #

_____	_____	____	_____	_____
Physician office address	City	State	Office phone	Office fax