

Montgomery, Alabama Office

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Please circle: **Neuro Consult/Testing** **Neuro Testing Only** **Sleep Consult/Testing** **Sleep Testing Only** **Sleep/Neuro Consult**

Patient Name: _____ Date: _____

Address: _____

Home Phone: _____ SSN#: _____

DOB: _____ Age: _____ Gender: Male Female **ESS:** _____

(Epworth
Sleepiness Score –
for Sleep Pts)

Height: _____ **Weight:** _____ **BMI:** _____ **Neck Cir:** _____**EEG Study(s) Req:**

- ☐ Routine EEG Recording ☐ Ambulatory Video EEG
☐ Long term Video EEG 24 Hr ____ 48 Hr ____ 72 Hr ____

Reason(s) for EEG:

____ CVA-h/o CVA ____ Headaches ____ Heart Disease
____ CHF-h/o CHF ____ Seizures /Epilepsy ____ Ischemic Heart Disease
____ High Blood Pressure ____ Pulmonary HTN ____ Conversion Disorder

Suspected Diagnosis:**Sleep Study(s) Req:**

- ☐ PSG/CPAP Titration ☐ **HST OK IF PSG DENIES?** ☐ MSLT/MWT
☐ CPAP Titration (In-Lab) ☐ Split Night Study (If Severe ☐ PSG/MSLT
OSA > 40/hr and O2 desat <85%) ☐ PSG only (In-Lab)
☐ HST (Home Sleep Test)

Reason(s) for Sleep Testing:

____ Snoring ____ Witnessed Apneas ____ History of OSA ____ Complex Sleep Apnea
____ Obesity ____ Restless Leg ____ History of Narcolepsy ____ Central Sleep Apnea
____ Gasping/Choking ____ Sleep Disturbance ____ Excessive Daytime Sleepiness ____ Parasomnias

Do any of these Co-Morbidities apply?

____ Impaired cognition/dementia ____ Diagnosed significant acute cardiac arrhythmia
____ Unexplained pulmonary hypertension ____ Known neurodegenerative disease
____ Moderate to severe congestive heart failure ____ Uncontrolled seizure disorder ____ Stroke (CVA)
____ Moderate to severe pulmonary disease – If so, *PFT/Blood Gas Test Results:* _____

Other: _____**Results of Previous Sleep Study:** _____ **Have Report? Y / N**

Please include: ***Physician Notes Supporting Need of Study** ***Copy of Insurance Card** ***Patient Demographics**

Referring Physician: _____ Facility: _____

Address: _____

Phone: _____ Fax: _____ NPI #: _____

Referring Physicians Signature: _____ **Date:** _____