

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: _____

Height: _____ Weight: _____ BMI: _____ Neck Cir: _____ (Epworth Sleepiness Score - for Sleep Pts)

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
[] HST (Home Sleep Test) OSA > 40/hr and O2 desat <85%) [] PSG only (In-Lab)

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: _____