Morton Hospital
A STEWARD FAMILY HOSPITAL
Steward

Sleep Study Request Form

SLEEP DISORDERS CENTER

Imad J. Bahhady, M.D.

Beth Mastria, PA-C

Patient Name: _____ DOB: _____ Phone:_____
Address: _____
Insurance: _____
Referring Physician (print): _____ Address: _____
Phone: _____ Fax: _____

PLEASE CHECK ONE:

☐ **Full Sleep Evaluation** (Includes: Consultation with Sleep Physician, Sleep Testing Order, ordering of CPAP/BiPAP and Follow-up Appointments as needed)

☐ **Sleep Testing Only** (Report will be sent to the ordering physician. The Sleep Center will NOT contact the patients with the results) Further orders for testing and CPAP are the responsibility of the ordering providers office.

✓	Testing Orders (Check One)	Date of last NPSG **Required for CPAP
	Nocturnal Polysomnography (NPSG)	
	CPAP Titration study only **	
	Multiple Sleep Latency Test (MSLT)	
	Maintenance of Wakefulness Test (MWT)	
	Split Night	
	Home Sleep Test (HST)	

Required:

Height:	Weight:

Symptom Review:

✓	Two Indications are REQUIRED
	Snoring
	Excessive Daytime Sleepiness
	Witnessed Sleep Disorder Breathing
	Restless Legs
	Insomnia

Epworth Sleepiness Scale:

Sitting and Reading	
Watching TV	
Sitting inactive in a public place	
As a passenger in a car	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car while stopped for a few minutes in traffic	
0-Never, 1-Slight Chance, 2-Moderate Chance, 3-High Chance	

Medical History:

	Hypertension		Obesity (BMI>28)		Stroke
	History of Coronary Disease		CHF		Seizures
	COPD		Diabetes Mellitus		Other:
	Hypothyroid		Neuromuscular Disease		

Special Needs:

	Electric Bed		Non-Ambulatory		Home O2_____L/min
	Group Home		Psychiatric History		CPAP/BiPAP at home

Physician Signature: _____ **Date/Time:** _____ **NPI Number:** _____

****** A COPY OF THE PATIENT'S LAST OFFICE VISIT AND INSURANCE CARD SHOULD BE FAXED WITH ORDER TO (508) 880-0716******