Nashoba Valley Medical Center
A STEWARD FAMILY HOSPITAL

THE SLEEP CENTER
200 Groton Road
Ayer, MA 01432
Phone (978) 784-9287
Fax (978) 784-9606

REQUEST FOR SLEEP STUDY

Referral date: _____ Patient name: _____ DOB: _____

Street: _____ Town: _____ State: _____ Zip: _____

Telephone: (_____) _____ Alternate phone: (_____) _____

Referring Physician Name: (PLEASE PRINT) _____

SLEEP PROBLEMS

__Witnessed Apneas
__ Frequent Awakenings
__ Insomnia
__ Nightmares
__ Restless Legs Syndrome
__ Excessive Daytime Sleepiness
__ Morning Headaches
__ Hypersomnia
__ Sleep Walking / Talking
__ Other: _____
__ Snoring
__ Tiredness / Fatigue
__ Cataplexy
__ Fragmented Sleep

MEDICAL CONDITIONS

__ Sinusitis
__Chronic Pain
__Hypertension
__ Depression
__ Anxiety
__ Claustrophobia
__COPD
__ Stroke/Seizures
__ Asthma
__Diabetes
__Congestive Heart Failure
__Cardiac Arrhythmias
__ Allergies: _____
__Special Needs: _____

TYPE OF STUDY REQUESTED

ICD.10: _____

__ HST (Home Sleep Test)
__ Diagnostic Polysomnogram
__ Split Night PSG
__ CPAP Titration
__ Bi-level Titration
__ End Expiratory Re-breathing Study
__ Supplemental O_2 _____ Liters

__ *CPAP Complete Therapy** *if criteria met during first 2 hours of study:
1) CPAP therapy is applied for the titration portion of the study.
2) **Preliminary** DME service will be ordered immediately through the sleep lab, using the Medical Director's recommended settings. Follow up DME services will be managed by the referring physician.

Physician Signature: _____ Date:_____

NVMC Sleep Center Medical Director Review: _____