



St. Joseph Mercy Hospital

Sleep Disorders Center
5301 East Huron River Dr.
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SLEEP STUDY DIRECT ORDER FORM

PATIENT NAME: _____ **DOB:** _____ **Normal Bedtime** _____ **A.M./P.M.**

Indication/Symptoms: (Check **ALL** that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Narcolepsy | <input type="checkbox"/> Snoring | <input type="checkbox"/> Restless Sleep |
| <input type="checkbox"/> <i>Cataplexy</i> | <input type="checkbox"/> Witnessed Apnea | <input type="checkbox"/> Non-Restorative Sleep |
| <input type="checkbox"/> <i>Sleep Paralysis</i> | <input type="checkbox"/> Gasp/Choke Awakenings | <input type="checkbox"/> Excessive Sleepiness |
| <input type="checkbox"/> <i>Hallucinations</i> | <input type="checkbox"/> Nasal Stuffiness | <input type="checkbox"/> Bruxism |
| <input type="checkbox"/> Parasomnia | <input type="checkbox"/> Restless Leg Syndrome | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> <i>Sleep Talking/Walking</i> | <input type="checkbox"/> Periodic Limb Movements | <input type="checkbox"/> REM Behavior Disorder |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Memory/Concentration Problems | <input type="checkbox"/> Obesity Hypoventilation |
| <input type="checkbox"/> Enuresis | <input type="checkbox"/> Nocturia | <input type="checkbox"/> Other _____ |

Requested Test:

- | | |
|---|--|
| <input type="checkbox"/> Polysomnogram Baseline Sleep Study (NPSG) | <input type="checkbox"/> CPAP Titration |
| <input type="checkbox"/> Polysomnogram with Multiple Sleep Latency Test (MSLT) | <input type="checkbox"/> CPAP/BIPAP Re-Titration |
| <i>Narcolepsy or Excessive Daytime Sleepiness must be indicated for MSLT to be preformed.</i> | Current Setting at _____ cmH2O |
| <i>MSLT will be canceled if AHI is >5</i> | Start at _____ cm H ₂ O |
| <input type="checkbox"/> Maintenance Wakeful Test (MWT) | <input type="checkbox"/> PAP Nap |
| | <input type="checkbox"/> Split Night Study |
| | <i>Will be performed only if laboratory criteria are met</i> |

Special Instructions: _____

Pertinent Patient Medical History:

- | | | |
|--|--|-------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> CHF |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Stroke | <input type="checkbox"/> Arrhythmia |
| <input type="checkbox"/> Coronary artery Disease | <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> GERD |
| <input type="checkbox"/> HTN | <input type="checkbox"/> Previous Surgery | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Other _____ | | |

Allergies: _____

Special Needs: _____

Physical Exam:

Height: _____ Weight: _____ Neck Circumference: _____
Oropharyngeal Exam: _____

**Please send History and Physical and / or office notes.*

Ordering Physician Signature

Date

Approval Signature

Date