THE SLEEP CENTER of Austin

Sleep Study Order Form
Phone: (512) 697-9896
Fax: (512) 697-9895
5508 Parkcrest Dr. Ste 200 Austin, TX 78731
www.thesleepcenteraustin.com

Patient Name: _____ DOB: _____ Contact Phone#:_____

Please also provide patient's demographics, insurance information, pertinent medical history and any recent sleep studies.

SLEEP HISTORY & PRESENTING SYMPTOMS (check all that apply)

- ☐ Snoring
- ☐ Witnessed Apnea
- ☐ Morning Headaches
- ☐ Nocturia
- ☐ Daytime Sleepiness / Fatigue
- ☐ Nocturnal Awakenings
- ☐ Impaired Cognition
- ☐ Insomnia
- ☐ Non Restorative Sleep
- ☐ Central Sleep Apnea
- ☐ Restless Leg/Periodic Limb Movements
- ☐ Stroke
- ☐ Hypertension
- ☐ Obesity (BMI: _____)
- ☐ CHF
- ☐ Other Symptoms:_____

SERVICES REQUESTED

☐ CONSULTATION AND MANAGEMENT

Initial consultation with Board Certified Sleep physician followed by appropriate testing, treatment, and ongoing sleep disorder management.

☐ SLEEP STUDY ONLY (please select study orders and diagnosis below)

Once the study is completed, our office will send the results to the ordering physician for follow-up with the patient.

INTERPRETING PHYSICIAN: ☐ Dr. Hudson/Dr. Tempest ☐ Other _____
(Must be board certified in sleep)

☐ POST TESTING CONSULT

Review of results with the patient at a consultation appointment after the study, initiation of treatment and on-going management by a Board Certified Sleep physician.

SLEEP STUDY ORDER (1 or more may apply)

- ☐ NPSG – overnight sleep study
- ☐ HST – home sleep study (AASM Accredited)
- ☐ CPAP Titration Study
- ☐ 2-Night Sleep study (NPSG diagnostic and CPAP titration if AHI ≥ 5)
- ☐ Bi-level Titration only
- ☐ ASV Titration only
- ☐ MSLT – multiple sleep latency test
- ☐ Split Night (if AASM criteria met)
- ☐ PAP-NAP
- ☐ Other: _____

SUSPECTED DIAGNOSIS

☐ R/O Sleep Apnea	327.23
☐ Treat OSA	327.23
☐ Treat CSA	327.21
☐ Treat Complex SA	327.21
☐ Re-Titration for OSA	327.23
☐ R/O PLMS	327.51
☐ R/O Narcolepsy	347.00
☐ Restless Leg Syndrome	333.94
☐ Other:_____	

☐ ARRANGE CPAP / BIPAP THERAPY

☐ After consultation with referring physician

Referring Physician Name: _____ **NPI:** _____

Office Phone #:_____ **FAX:** _____

Physician Signature: _____ **Date**: _____

FAX COMPLETED FORM TO: (512) 697-9895