THE University of Vermont MEDICAL CENTER

UVM Medical Center Sleep Program
1 South Prospect Street
Phone: (802) 847-5338/ Fax: (802) 847-0379

NAME: _____

DOB: _____

MRN: _____

Adult Sleep Study Order Form

Please check only one box:

☐ **Overnight Diagnostic Polysomnogram with SPLIT to CPAP/BiPAP Titration***
(For diagnosis with a possible initiation to CPAP titration treatment if patient meeting Sleep Lab Criteria)

☐ **Overnight Diagnostic Polysomnogram** (CPAP/BiPAP will NOT be started)
Using a Mandibular Advancement Device?____ Dentist_____
Additional Montage Required? Full Head __NMD ___ RBD__RBD w/ Full Head EEG___TcCo2___Other__
Additional Daytime Testing Required? MSLT ___ MWT__

☐ **Overnight CPAP/BiPAP Titration Polysomnogram ***
Polysomnogram Diagnosis of OSA: Year_____ Location_____
(If performed outside of UVMMC, please send copy of report with referral form)

☐ **Ambulatory Sleep Consult** (Sleep testing will be determined by the Sleep Center Provider)

☐ **Ambulatory Insomnia Consult** (For Cognitive Behavioral Therapy for Insomnia)

IMPORTANT regarding Polysomnograms – Ordering Provider:

- *The results of the study are sent to the Ordering Provider, who is responsible for conveying the results to the patient.*
- *Please discuss CPAP/BiPAP with the patient prior to the study if you are ordering a SPLIT or TITRATION study.*

* The *Sleep Center will send a prescription to a DME for the patient to obtain equipment AND the patient will be scheduled for an Ambulatory Sleep Consult if CPAP/BiPAP is initiated unless otherwise specified here by the Ordering Provider:* ***Check if prescription is not needed*** ____
Check if Sleep Consult is not needed ____

Please check yes or no:

SAFETY (In order to help ensure proper study location and level of assistance)

Yes / No Poor Mobility/Wheelchair/ Can not walk long distances/Needs Handicapped Bathroom
Yes / No Needs assistance with Toileting and/or Transfers in/out of bed or chair
Yes / No Cognitively Impaired
Yes / No Currently Using Nocturnal Oxygen ____LPM

Problem List: (For Insurance Authorization)

Yes / No CAD/HTN/CHF/A-FIB
Yes / No NMD/CVA/Neuro Degenerative Disease
Yes / No COPD/Lung Disease/Pulm HTN
Yes / No Chronic Hypercapneic Respiratory Failure

Height = _____
Weight =_____
BMI = _____

Symptoms

Yes / No Morning Sluggishness
Yes / No Reduced Day Time Functioning
Yes / No Abnormal Nocturnal Oximetry Study
Yes / No Unusual Behavior During Sleep
Yes / No RLS/Leg Movements
Yes / No Restless Sleep
Yes / No Snoring/Gasps
Yes / No Apnea/Pauses
Yes / No Hypersomnolence
Yes / No Frequent Awakenings

Epworth Sleepiness Scale (Please Complete if Ordering a Sleep Study)

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the *most appropriate number* for each situation.

0=would *never* doze
1=*slight* chance of dozing
2=*moderate* chance of dozing
3=*high* chance of dozing

Situation	Chance of Dozing
Sitting and reading.	0 1 2 3
Watching TV	0 1 2 3
Sitting, inactive in a public place (i.e.: a theater or a meeting)	0 1 2 3
As a passenger in a car for an hour without a break	0 1 2 3
Lying down to rest in the afternoon when circumstances Permit	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after a lunch without alcohol	0 1 2 3
In a car, while stopped for a few minutes in the traffic	0 1 2 3

Epworth Score ____

Specific Objectives of Consult/Sleep Study:

____R/O Sleep Apnea 786.09

____R/O Hypoventilation/Hypoxemia 786.09

____CPAP/BiPAP Titration for OSA 327.23

____BiPap Titration only 327.20

____Evaluate MAD effectiveness

____Hypersomnia 780.54A

____PLMS 327.51

____Parasomnia, Unspecified 327.40

____R/O REM Behavior D/O 327.42

____Unspecified Sleep disorder 327.8

For Prompt Scheduling, Please Include:

- **Relevant Office Notes, Problem List, Medication List**
- **Insurance Information**
- **Any Previously Performed Sleep Testing (outside our center)**

Date: _____ **Provider Signature:** _____**Ordering Provider:** _____**(Printed)**