



Johns Hopkins Sleep Disorders Center Request Form

For office use only

C or L
Date of study:

 Rev. Init. _____ Date: _____

Johns Hopkins Hospital
 Phone: 443-287-3313
 Fax: 443-287-3312

Johns Hopkins Bayview Medical Center
 Phone: 410-550-0571
 Fax: 410-550-3374

Patient Name: _____ MR#: _____

Patient Date of Birth: _____ Patient Contact Phone #: _____

Requesting Physician: _____ Phone: _____ Pager: _____

Requesting Physician Specialty: _____

Date of Request: _____ Date Study Scheduled: _____

SLEEP CLINIC EVALUATION – CHECK ONE BELOW:

Initial Sleep Clinic Evaluation **OR** Sleep Clinic Evaluation **after** sleep study
No other documentation is needed **(See below)**
Please sign second page

SLEEP STUDY – PLEASE CHECK ONE OF THE FOLLOWING:

Polysomnography

Standard Polysomnogram* Other, please specify: _____
 (on room air unless specified)

CPAP titration

CPAP/Bilevel study (Pressure = _____)

Special Needs or Instructions:

*I have discussed the procedure of a sleep study and CPAP titration with the patient Yes No

*I would like a CPAP titration study if this baseline study is consistent with sleep apnea Yes No

***** IF THIS IS A DIRECT REFERRAL FOR A SLEEP STUDY, A HISTORY AND PHYSICAL EXAM DOCUMENT IS REQUIRED FOR SLEEP STUDY. *****

***** PLEASE NOTE, THESE ORDERS EXPIRE 6 MONTHS FROM DATE OF SIGNATURE *****

REMINDERS:

1. Please let your patient know that you are requesting a sleep disorder evaluation or a sleep study.
2. Titration studies will NOT be scheduled until patient has had an evaluation in sleep clinic.
3. Medicare patients: for sleep study, clinic note MUST contain indication for study and a detailed sleep history. Physical exam (neuro, ENT, CV, weight, and VS), and functional limitations related to sleep disturbance ***If this is not included, a sleep clinic appointment will be scheduled first.***



Sleep Disorders Center Request Form, Page 2

Pertinent History:

Is the patient under treatment for hypertension? Yes No Unknown
 Has the patient ever had congestive heart failure? Yes No Unknown
 Does the patient have pulmonary hypertension? Yes No Unknown

Check all that apply:

- | | |
|-------------------------------------------------------------------------|-------------------------------------------------------------------|
| <input type="checkbox"/> Witnessed apneas during sleep | <input type="checkbox"/> Weight changed >1 lbs in the past year |
| <input type="checkbox"/> Awakens with choking or gasping sensation | <input type="checkbox"/> Frequent nocturnal awakenings to urinate |
| <input type="checkbox"/> Disruptive Snoring | <input type="checkbox"/> Hypnagogic/hypnapompic hallucinations |
| <input type="checkbox"/> Daytime Sleepiness | <input type="checkbox"/> Sleep paralysis |
| <input type="checkbox"/> MVA or close call from falling asleep at wheel | <input type="checkbox"/> Cataplexy |
| <input type="checkbox"/> Tired in morning after sleep at night | <input type="checkbox"/> Hx or narcolepsy |
| <input type="checkbox"/> Awakens with a headache | <input type="checkbox"/> Hx restless legs |
| <input type="checkbox"/> History of PTSD | <input type="checkbox"/> Hx of fibromyalgia |

Complete only if patient has already been diagnosed with sleep apnea:

When diagnosed with OSA: _____
 Patient currently on CPAP or BPAP Yes No Pressure settings: _____
 Any other treatment for sleep apnea? If yes, what? Yes No _____
 Any prior Sleep Studies? If yes, provide study date(s) and results: _____

Other Pertinent History: _____

Pertinent Physical Exam Findings (BP, upper airway, lung/cardiac exam):

Blood Pressure: _____ Respirations: _____ Height: _____ Weight: _____
 Nose: WNL; Other: _____
 Throat: WNL; Other: _____
 Pharynx: WNL; Other: _____
 Cardiovascular Exam: WNL; Other: _____
 Neurological Exam: WNL; Other: _____

MD Signature **(Required)** Date

MD Printed Name

REMINDER: (Be sure to indicate on page 1 whether patient should come first to clinic or lab)

Revised 12/6/10