CULLMAN REGIONAL

Professional Office Building 3, Suite 202
1800 Alabama Highway 157
Cullman, AL 35058
Phone 256-737-2140
Fax 256-737-2756

OUTPATIENT SLEEP STUDY ORDER

Patient name _____

DOB_____ Phone _____

SLEEP PROBLEMS *Must have one of the following*

- ☐ Excessive daytime sleepiness
- ☐ Frequent awakenings
- ☐ Witnessed apnea
- ☐ Snoring
- ☐ Tiredness/fatigue
- ☐ Insomnia
- ☐ Sleepwalking
- ☐ Shiftwork
- ☐ Other

TEST ORDERED

☐ **Diagnostic Study**

- ☐ Split night per protocol
- ☐ Expanded EEG (Temporal, unless otherwise specified
- ☐ MSLT if negative for OSA

☐ **Titration Study**

☐ CPAP ☐ BIPAP ☐ AVAP

Previous Diagnostic Sleep Study required

☐ Begin at home pressure

☐ MWT (Maintenance of wakefullness ☐ Home Study

Medication(s): Patient may self-medicate with own prescribed medication(s) for sleep study.

Standing order: Sleep Aid* for sleep initiation/ maintenance (Follow Policy #7-5)

*Trazodone 50mg PO — may repeat Trazodone 50mg PO for continued wakefulness

*Zolpidem CR 6.25mf PO (prior to 2330 hrs) if unable to take Trazodone

If unable to take Trazodone or if insomnia persists after 100mg Trazodone after midnight, then give Zaleplon (Sonata) 10mg

– Sinemet 25/100mg PO, if needed for limb movements with arousals

– Clonazepam 0.5mg PO for PLMs with arousals that persist after Sinemet is given

– Imodium AD PO PRN diarrhea dosage: Adults: 4mg; Children 6-12 yrs. Old: 2mg; Children 2-6 yrs old: 1mg

– Acetaminophen 650mg PO every 4 hours PRN pain. If patient prefers, may give ibuprofen 400mg PO q 6 hrs. PRN pain

– Mylanta, 1 tablespoon PO PRN indigestion

– Robitussin DM 1-2 teaspoons PO every 4 hours PRN for cough

– Neo-Synephrine Nasal Spray: 2 sprays in each nostril x 1 PRN congestion

We are required by the American Board of Sleep Medicine to obtain a recent H&P for all patients referred for a direct sleep study. Please include the latest office note and fill out the H&P on the back of this sheet. Also include a list of medications and any insurance information you may have

Referring Physician Signature _____ Date/Time _____

Director of Sleep Lab _____ Date/Time _____

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☐ **Study Confirmed** ☐ **H&P**

Date Scheduled _____ S M T W TH F Time _____ Monitoring Tech_____

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PATIENT HISTORY & PHYSICAL

Patient name _____

DOB _____ Phone _____

Referring Physician _____

Office Phone _____ Office Fax _____

HISTORICAL & PHYSICAL

Height_____Weight_____ Epworth Sleepiness Score _____Neck Circumference _____

MEDICAL CONDITIONS/ALLERGIES *Must have one of the following*

- ☐ Hypertension
- ☐ GERD
- ☐ COPD/Asthma
- ☐ CHF
- ☐ Diabetes
- ☐ Allergies
- ☐ Cardiac arrhythmias
- ☐ Stroke/Seizures
- ☐ Other

DIAGNOSIS

- ☐ Sleep Apnea
- ☐ Narcolepsy
- ☐ Insomnia
- ☐ Morning headaches
- ☐ Hypersomnia
- ☐ Nocturnal seizures
- ☐ PLMD/restless legs
- ☐ Sleepwalking
- ☐ Other

SPECIAL NEEDS

- ☐ Supplemental 0^2
- ☐ ADA Room
- ☐ Seizure montage
- ☐ Wheelchair/assistance walking
- ☐ Incontinence Problems
- ☐ Tape, latex or talc allergy
- ☐ Other

FOLLOW-UP REVIEW RESULTS WITH THE PATIENT

- ☐ Prescribing physician
- ☐ Interpreting physician – the center will schedule patient with a sleep specialist

CPAP TREATMENT

- ☐ Prescribing physician
- ☐ Interpreting physician – requires patient be seen by a sleep specialist

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Signature_____ Date _____