

OUTPATIENT SLEEP STUDY ORDER

Patient name _____

DOB _____ Phone _____

SLEEP PROBLEMS *Must have one of the following*

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Excessive daytime sleepiness | <input type="checkbox"/> Snoring | <input type="checkbox"/> Sleepwalking |
| <input type="checkbox"/> Frequent awakenings | <input type="checkbox"/> Tiredness/fatigue | <input type="checkbox"/> Shiftwork |
| <input type="checkbox"/> Witnessed apnea | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Other |

TEST ORDERED

- | | |
|---|---|
| <input type="checkbox"/> Diagnostic Study <ul style="list-style-type: none"><input type="checkbox"/> Split night per protocol<input type="checkbox"/> Expanded EEG
(Temporal, unless otherwise specified)<input type="checkbox"/> MSLT if negative for OSA | <input type="checkbox"/> CPAP Titration Study <ul style="list-style-type: none">Previous Diagnostic Sleep Study required<input type="checkbox"/> Begin at home pressure<input type="checkbox"/> MWT (Maintenance of wakefulness) |
|---|---|

*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 _____

FOR OFFICE USE ONLY Study Confirmed H&P

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

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*

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> GERD | <input type="checkbox"/> COPD/Asthma |
| <input type="checkbox"/> CHF | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Cardiac arrhythmias | <input type="checkbox"/> Stroke/Seizures | <input type="checkbox"/> Other |

DIAGNOSIS

- | | | |
|---|---------------------------------------|---|
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Narcolepsy | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Morning headaches | <input type="checkbox"/> Hypersomnia | <input type="checkbox"/> Nocturnal seizures |
| <input type="checkbox"/> PLMD/restless legs | <input type="checkbox"/> Sleepwalking | <input type="checkbox"/> Other |

SPECIAL NEEDS

- | | | |
|--|--|--|
| <input type="checkbox"/> Supplemental O ₂ | <input type="checkbox"/> ADA Room | <input type="checkbox"/> Seizure montage |
| <input type="checkbox"/> Wheelchair/assistance walking | <input type="checkbox"/> Incontinence Problems | <input type="checkbox"/> Tape, latex or talc allergy |
| <input type="checkbox"/> Other | | |

FOLLOW-UP REVIEW RESULTS WITH THE PATIENT

- | | |
|--|--|
| <input type="checkbox"/> Prescribing physician | <input type="checkbox"/> Interpreting physician – the center will schedule patient with a sleep specialist |
|--|--|

CPAP TREATMENT

- | | |
|--|--|
| <input type="checkbox"/> Prescribing physician | <input type="checkbox"/> Interpreting physician – requires patient be seen by a sleep specialist |
|--|--|

FOR OFFICE USE ONLY

Signature _____ Date _____