Geneva General Hospital Sleep Laboratory
196 North St
Geneva, NY 14456
Phone: 315-787-4555 Fax: 315-787-4865

Referral Information and Sleep Study Order Form
Complete as much information as possible and fax or call the numbers above.

Patient Name: _____ DOB:_____
Address:_____
City:_____ State:_____ Zip code:_____
Phone#: Home:_____ Work:_____
Insurance/HMO:_____
Ordering Physician:_____ Phone:_____
Office Contact:_____ Fax:_____

Reason for Sleep Study: Please check all that apply – (Requirement for Insurance)

___Daytime Sleepiness	___Observed Apneas	___Pos. Nocturnal O_2 Desat.
___Leg Jerks/Restless legs	___Snoring	___Morning Headaches
___High Blood Pressure	___Nocturnal Choking	___Cataplexy
___Evaluate Current CPAP Tx	___Restless Sleep	___Sleep Disruptions/Unknown Cause
___Post-op	___Other: _____	

Test Type:
___NPSG (nocturnal Polysomnography-straight sleep study)
___CPAP Titration Study
___Split-night Study (straight study first part of night, with addition of CPAP per laboratory protocol)
___MSLT (multiple sleep latency testing)
Special Instructions/Comments:_____
_____

Special Needs (i.e. Wheelchair, Hearing Impaired, Walker, Help out of bed, etc.): _____

_____

Is Patient currently on Oxygen or CPAP? Yes/No

_____ _____
Physician Signature Date

Study date:_____