Memorial Hospital at Towanda

Referral Information and Sleep Study Order Form
Complete as much information as possible
Fax or call the Cardiopulmonary Registration Dept. at Memorial
Phone: 570-268-2537 Fax: 570-265-5859

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

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:___________________________