SLEEP STUDY ORDER FORM

MERIT Sleep Centers

Phone: (888) 637-4848 Fax: (630) 652-7946

PATIENT

Patient Name:______________________ Date of Birth:__________

Parent Name:______________________

Address:______________________

City:______________ State:__________ Zip:__________

Phone: (Home)__________ (Cell)__________ (Work)__________

Check One:

- ☐ Adult
- ☐ Pediatric
- ☐ Priority/Surgical
- ☐ STAT

SLEEP STUDY REQUIREMENTS

Diagnosis: ______________________

List any special patient accommodations : ______________________

STUDY TYPE (Check all that apply):

- ☐ Standard Sleep Study **(CPAP initiated if severe apnea observed in accordance with AASM guidelines for Split-Night Criteria, AHI $\geq$ 40 during the first 2 hours of sleep)**
- ☐ Diagnostic Sleep Study Only **(CPAP will not be initiated)**
- ☐ Diagnostic Sleep Study followed by an MSLT **(Multiple Sleep Latency Test)**
- ☐ CPAP Titration **(Copy of prior Sleep Study confirming diagnosis required)**
- ☐ Oral Appliance Titration
- ☐ A Patient Pre-Study Consultation by Sleep Medical Director (D, ABSM)
- ☐ A Patient Post-Study Consultation by Sleep Medical Director (D, ABSM)
- ☐ Professional Interpretation to be performed by ______________________ **(ABSM Physician Required)**
  (If left blank the Medical Director will perform the interpretation)

CPAP THERAPY

☐ If indicated, initiate Auto/ CPAP Therapy post-study through Merit Sleep Technologies

LOCATION

MERIT Locations (Please check the preferred center): (If blank, patient will be given a choice)

☐ PATIENT PREFERENCE	☐ Hoffman Estates	☐ St. Charles	☐ River Forest (March 2009)
☐ Arlington Heights	☐ Lombard	☐ Streamwood (Dedicated Pediatric & Adolescent)	☐ Chicago Northwest (March 2009)
☐ Chicago Lakeshore (Loop)	☐ Naperville	☐ Prairie Stone (West Hoffman Estates)	☐ Evanston (March 2009)
☐ Elmhurst	☐ Oak Park	☐ Lincoln Park	

HISTORY & PHYSICAL INFORMATION

The American Academy of Sleep Medicine (AASM) requires the following patient information or attach most recent chart note *or* history & physical related to suspected diagnosis.

Symptoms:

☐ Snoring	☐ Nocturnal Gasping	☐ Crawling Sensation/Cramps in Legs
☐ Witnessed Apnea	☐ Sleep Walking/Talking	☐ Excessive Daytime Sleepiness (EDS)
☐ Frequent Awakenings	☐ Morning Headaches	☐ Chronic Fatigue

Physical Exam:

Date of Completed History & Physical:______________________

Illnesses Under Treatment:______________________

Medications: (or attach list) ______________________

______________________ Sleep Aides:______________________

Check all that apply:

☐ Cardiac Disease	☐ Learning Difficulties	☐ Abnormal Oropharynx
☐ Diabetes	☐ Hyperactivity	☐ Enlarged Neck Circumference ________ Inches
☐ Hypertension	☐ Seizures	☐ Deviated Septum
☐ OSA	☐ Depression	☐ Obesity/Weight Gain Ht:________ Wt:________ BMI:________

☐ Other:______________________

______________________ ______________________ __________

Physician / Dentist Name **Signature** **Date**

Please fax this form and attachments to (630) 652-7946. For questions, please call and ask for the Sleep Dept.

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