Physician Intake

Please fill out Section A and Section C.

Complete Section B only if information is not available in EHR or attached notes.

Patient: _____ Birth Date: _____

Patient Address: _____

Patient Phone Number: _____

Gender: _____ Height: _____ Weight: _____ Date: _____

SECTION A – Sleep Symptoms

☐ Snoring ☐ Witnessed apneas ☐ Daytime Sleepiness ☐ _____

SECTION B – Medical History

Only complete this section if information is not available in EHR or attached notes.

Is patient on home oxygen? ☐ No ☐ Yes _____ LPM

Is patient a shift worker? ☐ Yes ☐ No

Medical History

☐ Hypertension ☐ Atrial fibrillation ☐ Depression

☐ Coronary artery disease ☐ Seizure disorder ☐ _____

☐ Congestive heart failure ☐ Neuromuscular disorder

Per AASM Clinical Practice Guidelines:

1. Does patient have high pretest probability or moderate to severe OSA? If no, in lab test done. If yes, go to question 2.
2. Does patient have signs or symptoms of comorbid medical disorders? If yes, in lab test done. If no, go to question 3.
3. Does patient have signs or symptoms of comorbid sleep disorders? If yes, in lab test done. If no, either in lab or home study.

Referring provider's choice for testing: ☐ In Lab Sleep Test ☐ Home Test

Patient will be scheduled for most appropriate test after reviewed by sleep specialist.

SECTION C

Referring Physician/Practitioner Signature: _____ Date: _____

Time: _____

TO BE COMPLETED BY SLEEP SPECIALIST

Procedures: ☐ PSG ☐ Home Test ☐ MSLT ☐ MWT

Criteria to initiate CPAP 2hr. sleep baseline + AHI > _____ 15 20 30 40

Titrations: ☐ CPAP ☐ BIPAP ☐ ASV ☐ IVAPS

Sleep Specialist Signature: _____ Date: _____ Time: _____