Sleep Study Order Form

Sleep Disorder Associates of Lancaster

250 Ranck Avenue
Lancaster, PA 17602
Tel: (717) 399 7451

For prompt processing use our fax line:

(717) 399-8128

Office Use Only

Computer:_____ Hospital: ☐
Intro letter:_____ Cx list: ☐
Location: _____
Study Date: _____
Time: _____
Technologist: _____

Type of Study Requested

- ❑ Split Study - Diagnostic sleep study with CPAP/BIPAP titration study
  (IF INADEQUATE SLEEP TIME, A CPAP TITRATION WILL BE SCHEDULED FOR THE PATIENT)
- ❑ Diagnostic sleep study only
- ❑ CPAP/BIPAP titration study only
- ❑ Diagnostic sleep study and MSLT if indicated (Multiple Sleep Latency Test)
- ❑ MWT (Maintenance of Wakefulness Test)
- ❑ Home sleep test (unattended study in the home)

Authorizing Signature: _____ Date:_____

Study Indications

- ❑ Snoring and Excessive Daytime Sleepiness
- ❑ Witnessed Apneas and Excessive Daytime Sleepiness
- ❑ Excessive Daytime Sleepiness
- ❑ Other _____
- ❑ Previous study done – please include copy of prior test results, if not completed by Sleep Disorder Assoc

Medical History:

- ❑ Supplemental oxygen ltrs/min _____
- ❑ Periodic Limb Movements during sleep
- ❑ Restless Legs while falling sleep
- ❑ Circadian rhythm disorder
- ❑ Parasomnias
- ❑ Pulmonary disease
- ❑ Neuromuscular disease
- ❑ Congestive heart failure

Physician Information

Referring Physician: _____

Practice Name: _____

Phone: _____ Fax: _____

Patient Information

Patient Name: _____ SSN: _____

Street Address: _____ DOB _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone:_____ Cell Phone:_____
(secondary phone)

Insurance Information

Primary Insurance: _____ Primary ID: _____

Primary Phone: _____ Group Number: _____

Secondary Insurance: _____ Secondary ID: _____