UNITED INC.
SLEEP DIAGNOSTICS
Everyone deserves a good night's sleep

SLEEP STUDY EXPRESS ORDER FORM

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Patient Name _____ ☐ *Male* ☐ *Female* *DOB* _____ / _____ / _____

Patient Address _____ *SS #* _____

City _____ *State* _____ *Zip* _____ *Height* _____ *Weight* _____

Patient Tel: H (____ *)* _____ *W (* ____ *)* _____ *C (* ____ *)* _____

Insurance _____ *ID #* _____

Is the patient the insured ☐ *Yes* ☐ *No* *If no, insured's name & DOB* _____

TYPE OF STUDY REQUESTED

☐ *DIAGNOSIS & TREATMENT – Sleep Study, Titration and initiation of therapy if needed*
☐ *PSG, Initial nocturnal polysomnography*
☐ *TITRATION, Follow-up study with PAP titration*
☐ *MSLT, Multiple sleep latency test (nap studies)*
☐ *SPLIT, baseline study followed by PAP titration*
☐ *MWT, Maintenance of wakefulness test*
☐ *Sleep Specialist Evaluation*

PATIENT HISTORY

Patient's chief complaint (mandatory) _____

Significant Co-Morbidities *Please check all that apply*

Suspected Complex Sleep Disorders	☐ *Narcolepsy*	☐ *Circadian rhythm*	☐ *Parasomnia's*	☐ *Restless Legs*
Cardiac Disease	☐ *Heart Failure*	☐ *Arrhythmia*	☐ *Pulmonary hypertension*	☐ *MI*
Lung Disease	☐ *COPD*	☐ *Chronic Respiratory failure*		
Neuromuscular Disease	❑ *Cognitive Impairment*	❑ *Neuromuscular Weakness*		

Sleep Health Maintenance History *Please check all that apply:*

☐ *Loud snoring*	☐ *Twitching or kicking of legs while sleeping*	☐ *Stroke*
☐ *Hypertension*	☐ *Obesity*	☐ *Nocturnal seizures*
☐ *Excessive daytime sleepiness*	☐ *Gasping for air at night*	☐ *Type 2 Diabetes*

Has the patient been tested previously? ☐ *Yes* ☐ *No*
(If yes, please fax copy of results) *Date of Last Study* _____

Referring Physician _____ *Tel: (* _____ *)* _____

Address _____ *Fax: (* _____ *)* _____

Signature _____ *NPI #* _____ *Date:* _____