Legacy Sleep Center

Sleep study referral form

LEGACY HEALTH

Patient name _____ Phone _____ Date of birth *(mm/dd/yyyy)* _____

Address _____ City _____ State _____ ZIP _____

Insurance _____ Insurance authorization # _____ Date range _____

Please attach a copy of insurance card, demographic information, history and physical, chart notes with indication for sleep study, problem list, medication list and significant allergies.

Indications for sleep study

- ☐ Sleep apnea
- ☐ Snoring
- ☐ Hypercapnia/hypoventilation
- ☐ Abnormal movements
- ☐ Narcolepsy
- ☐ Observed apnea
- ☐ Bariatric surgery
- ☐ CHF/CAD
- ☐ REM behavior disorder
- ☐ Seizures
- ☐ Complex sleep apnea
- ☐ Pulmonary hypertension
- ☐ Cardiac arrhythmia
- ☐ Bruxism
- ☐ Diabetes
- ☐ Excessive daytime sleepiness
- ☐ Hypertension
- ☐ Parasomnia
- ☐ RLS/PLMD

☐ Other *(please specify)* _____

Sleep study referral

○ Legacy Good Samaritan Medical Center
Fax: 503-413-6919

○ Legacy Meridian Park Medical Center
Fax: 503-692-7336

○ Legacy Mount Hood Medical Center
Fax: 503-674-1281

The ordering provider is responsible for discussing test results with patient and initiating treatment, if indicated.

☐ Split-night study — Diagnostic + CPAP/bilevel titration if Legacy Sleep Center criteria are met

☐ Diagnostic testing only — No CPAP/bilevel

☐ CPAP/bilevel titration — Must provide prior sleep study

☐ Home sleep apnea test — Legacy Good Samaritan or Legacy Mount Hood. *Requires a sleep specialist consultation.*

☐ Home sleep apnea test — Legacy Meridian Park. *A sleep specialist consultation is not required, but a response to all the questions below **is** required. If any answer is yes, please order a referral with a sleep provider instead.*

- ○ Yes ○ No Does patient have moderate to severe COPD?
- ○ Yes ○ No Does patient have moderate to severe CHF?
- ○ Yes ○ No Does patient have a concern for central apnea, i.e., patient is on opiate narcotics?
- ○ Yes ○ No Does patient have neuromuscular disease?
- ○ Yes ○ No Does patient have cognitive or mobility issues that would make using testing equipment difficult?
- ○ Yes ○ No Does patient use home oxygen?
- ○ Yes ○ No Has patient had a CVA within 30 days?
- ○ Yes ○ No Is there concern for other sleep disorders besides OSA?

Also available — These studies require a sleep specialist consultation.

☐ MSLT ☐ MWT ☐ ASV titration ☐ Parasomnia/REM behavior study ☐ Seizure study ☐ Actigraphy ☐ PAP-NAP

If a sleep aid is indicated, please provide for the patient before coming to the Legacy Sleep Center.
Note: By signing below, I signify that the patient has been deemed capable of self-administering his or her own medication.

Oxygen will be administered per Legacy Sleep Center protocol. Patient currently on home oxygen at _____ lpm.

☐ ABG pre-study (Legacy Good Samaritan and Legacy Meridian Park only)

☐ ABG post-study (Legacy Good Samaritan and Legacy Meridian Park only). ABGs may also be drawn per Legacy Sleep Center protocol.

Special needs _____

Referring physician _____ Phone _____ Fax _____

Address _____ City _____ State _____ ZIP _____

Physician signature _____ Date _____