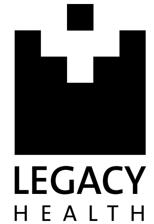
Legacy Sleep Center



Sleep study referral form

○ 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)

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

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 — *A response to all the questions below is **required**. If any answer is yes, please order a referral to 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., is patient 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.

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

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
☐ ABG post-study — ABGs may also be drawn per Legacy Sleep Center protocol.

Special needs ______________________________

Referring physician ______________________ Phone ______________ Fax ______________

Address ______________________ City ______________ State ______ ZIP __________

Physician signature ______________________________ Date __________

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