NYMetroSleep & Neurology Center
Center for the diagnosis and treatment of sleep disorders

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AMERICAN ACADEMY OF SLEEP MEDICINE — WAKE SLEEP — ACCREDITED MEMBER CENTER

Request for Polysomnography (Sleep Study)

PATIENT INFORMATION:

Last Name: _____First:_____MI:_____Sex: M F
Address: _____City:_____State:_____Zip:_____Email:_____
Phone (H): _____ W) _____(C) _____ Date of Birth: _____
Primary Insurance Carrier: _____ Policy/ID#_____
Secondary Insurance: _____ Policy/ID#_____

Please submit a photocopy of the patient's insurance card (FRONT AND BACK)

TEST REQUESTED: (Check Applicable)

- ☐ **Please schedule a consultation with a Sleep Specialist**
- ☐ **Full service polysomnography (PSG), if positive CPAP/Bi-PAP/ASV Titration**
- ☐ Dental Sleep Medicine Evaluation/Oral Appliance Therapy
- ☐ Split-night polysomnography (at least 2 hrs. of diagnostic study followed by CPAP/BiPAP Titration if needed)
- ☐ Multiple Sleep Latency Test (MSLT) or Maintenance of Wakefulness test (MWT)
- ☐ Home Study
- ☐ Consultation with Behavioral Sleep Medicine Specialist (For Insomnia)
- ☐ CPAP Center- EVALUATION (CPAP Machine order/supplies/mask fitting/maintenance)

Indications: (Check Applicable)

☐ Obstructive Sleep Apnea	☐ Circadian Rhythm Disorder	☐ Pre/Post Surgery
☐ Parasomnia	☐ Central Sleep Apnea	☐ Narcolepsy
☐ Physiological insomnia	☐ RLS/PLMD	☐ Other : _____
☐ Neurologic problem/Autism		

Symptoms:

☐ Daytime Sleepiness	☐ Witnesses Apneas	☐ Arrhythmia	☐ GERD	☐ Diabetes
☐ Shortness of Breath	☐ Choking during Sleep	☐ HTN	☐ Dyslipidemia	☐ Non-restorative sleep
☐ Obesity				

MEDICAL HISTORY: (Faxed history and physical preferred)

☐ Asthma	☐ Ischemic heart disease	☐ Large tonsils	☐ Psychiatric Disorder
☐ Emphysema	☐ Diabetes	☐ Nasal obstruction	☐ Hypertension
☐ Seizures	☐ Stroke	☐ Enlarged tongue	☐ Claustrophobia
☐ Other_____			

NEUROLOGY

☐ Consultation	☐ VNG
☐ EMG / NCV	☐ VEEG
☐ EEG	☐ 72 HOURS ☐ 48 HOURS ☐ 24 HOURS

Reason for Referral/Please include Medical Notes: _____

_____

REFERRING PHYSICIAN

NAME: _____SIG._____ DATE:_____

ADDRESS: _____PHONE: _____

_____ FAX: _____

NPI: _____ EMAIL: _____

PATIENT'S PCP: _____ PHONE: _____