BOYS TOWN National Research Hospital

Patient Label or
Patient Name
DOB or MR#

Adult Sleep Study Order Set

FAX ALL DOCUMENTS TO:
Outpatient Diagnostic Scheduling
Fax 531-355-0026
Phone 531-355-6737

Today's Date: _____

Referring Provider: _____ Phone: _____

Provider Specialty: _____ Fax: _____

Thank you for referring your patient to the Sleep Disorders Center. Please fax the following information so we can provide the best and most timely service:

- Insurance and Demographic information
- Most recent H &P and/or clinic note on the patient you are referring

Patient Name: _____ Date of Birth: _____ Phone: _____

Adult Sleep Study Requested:

☐ Home Sleep Study
☐ Adult Sleep Study Split night if qualifies
☐ PAP Titration Sleep Study current PAP settings_____

Comments: _____

Current Diagnoses (check all that apply):

☐ Snoring	☐ Obstructive Sleep Apnea	☐ Choking / Gasping
☐ Morning headaches	☐ Central Sleep Apnea	☐ Sleep Disturbance
☐ Witnessed Apnea	☐ Daytime Sleepiness	☐ Insomnia
☐ Restless Leg Syndrome	☐ Periodic Limb Movements	☐ Obesity

☐ Other _____

Provider Signature: _____ Date: _____ Time: _____