Morton Hospital
BROWNHealth
UNIVERSITY

Sleep Disorders Request Form

Imad J. Bahhady, MD
Beth Mastria, PA-C

Patient Name: _____ DOB: _____ Phone: _____ Height: _____ Weight: ____

Address: _____ Insurance: _____

Referring Physician (print): _____ NPI #: _____

Phone: _____ Fax: _____

PLEASE CHECK ONE:

□ **Full Sleep Evaluation** (Includes: Consultation with Sleep Physician, sleep testing order, ordering of home equipment, and follow-up appointments as needed)

□ **Sleep Testing Only**: (Ordering physician will manage all patient needs including further orders and referrals)

Select One:	**Testing Orders**	Date of Last PSG *Required for CPAP Titration*
	Polysomnography (PSG)	
	CPAP Titration Study*	
	Multiple Sleep Latency Test (MSLT)	
	Maintenance of Wakefulness Test (MWT)	
	Split Night	
	Home Sleep Test (HST	

Symptom Review: Two Indications are REQUIRED	
	Snoring R06.83
	Excessive Daytime Sleepiness F511
	Witnessed Sleep Disorder Breathing
	Restless Legs G25.81
	Insomnia G47.00

Medical History					
	Hypertension		Obesity (BMI>28)		Stroke
	Hx. Of Coronary Disease		CHF		Seizures
	COPD		Diabetes Mellitus		Other:
	Hypothyroid		Neuromuscular Disease		

Special Needs					
	Electric Bed		Non-Ambulatory		Home O2_____L/min
	Group Home		Psychiatric History		CPAP/BiPAP at home

Physician Signature: _____ **Date/Time:** _____

**** A COPY OF THE PATIENT'S LAST OFFICE VISIT AND INSURANCE CARD SHOULD BE FAXED WITH ORDER TO (508) 880-0716****

91 Washington Street, Suite 203, Taunton, MASSACHUSETTS 02780
TEL: (508) 880-0713