

Atlantic

Sleep and Rehab Centers

APPOINTMENT LINE: (910) 681-1050

REFERRAL E-FAX: (800) 977-2752

7211 Ogden Busniess Lane
Wilmington, NC 28411

Patient: _____ DOB: _____

Address: _____

Phone/Home: _____ Cell: _____ Other: _____

(Please include office notes and insurance information)

Primary Insurance: _____ Secondary Insurance: _____

SELECT TYPE OF STUDY:

- Diagnostic Polysmnography (Sleep Study)
- CPAP / BILEVEL Titration Polysmnography
(only if obstructive sleep apnea previously documented by sleep study)
- Split Diagnostic (if criteria for obstructive sleep apnea is met)
- MSLT / Multiple Sleep Latency Test (following Diagnostic Polysmnography)
- MWT / Multiple Wake Test

DIAGNOSIS: _____

SYMPTOMS / SIGNS:

- | | | |
|---|---------------------------------|---|
| <input type="checkbox"/> Hypersomnolence/excessive sleepiness | <input type="checkbox"/> CHF | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> MI | <input type="checkbox"/> Irritability / behavioral disorder |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Stroke | <input type="checkbox"/> Cognitive impairment |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> HTN | <input type="checkbox"/> Enuresis / bed wetting |
| <input type="checkbox"/> Witnessed Apnea | <input type="checkbox"/> COPD | <input type="checkbox"/> Morning Headache |
| <input type="checkbox"/> Patient currently on OXYGEN | <input type="checkbox"/> NO | <input type="checkbox"/> YES (LPM: _____) |

REFERRING PHYSICIANS:

Please indicate if you want the interpreting physician to notify the patient of their sleep study results.

YES NO FOLLOW UP AS NEEDED? YES NO

Physician Signature

NPI NUMBER

Date

Printed Physician Name