



SLEEP STUDY EXPRESS ORDER FORM

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PLEASE CHECK LOCATION PREFERENCE

BROOKLYN

QUEENS

NASSAU

ROCKLAND

SUFFOLK

Bay Ridge

Bayside

Garden City Park

Blauvelt

Commack

Hicksville

Shirley

Patient Name Male Female DOB / /

Patient Address SS #

City State Zip Height Weight

Patient Tel: H () W () C ()

Insurance ID #

Is the patient the insured Yes No If no, insured's name & DOB

Insurance Co. Tel: ()

TYPE OF STUDY REQUESTED

- DIAGNOSIS & TREATMENT - Sleep Study, Titration and initiation of therapy if needed
PSG, Initial nocturnal polysomnography
TITRATION, Follow-up polysomnography with CPAP / Bilevel titration if indicated
SPLIT, baseline polysomnography at least 2 hours followed by CPAP / Bilevel titration if indicated
MSLT, Multiple sleep latency test (nap studies)
MWT, Maintenance of wakefulness test
Evaluation by Sleep Specialist

PATIENT HISTORY

Patient's chief complaint (mandatory)

Does the patient stop breathing while asleep? Yes No

Does the patient snore excessively? Yes No

Does the patient wake up gasping for air? Yes No

Does the patient kick, jerk or twitch legs while asleep? Yes No

Has the patient been tested previously? Yes No

(If yes, please fax copy of results) Date of Last Study

Patient on CPAP? If so, pressure

Patient was seen in office today? Yes No

Patient on Oxygen? Yes No

Does the patient have insomnia? Yes No

Please check all that apply:

- Enlarged tongue Diabetes
Morbid Obesity Emphysema
Anemia Thyroid Disease
Asthma High Blood Pressure
Heart disorder Enlarged tonsils
Psychiatric disorder
Compromised Oropharyngeal space
Known EKG Arrhythmias
Other

Date of Last Study

Referring Physician Tel: ()

Address Fax: ()

Signature NPI # Date: