JOHNS HOPKINS MEDICINE

Johns Hopkins Sleep Disorders Center Request Form

For office use only
C or L
Date of study:
Rev. Init._____Date:_____

☐ **Johns Hopkins Hospital**
Phone: 443-287-3313
Fax: 443-287-3312

☐ **Johns Hopkins Bayview Medical Center**
Phone: 410-550-0571
Fax: 410-550-3374

Patient Name: _____ MR#:_____

Patient Date of Birth: _____ Patient Contact Phone #:_____

Requesting Physician: _____ Phone: _____ Pager: _____

Requesting Physician Specialty: _____

Date of Request: _____ Date Study Scheduled: _____

SLEEP CLINIC EVALUATION – CHECK ONE BELOW:

☐ Initial Sleep Clinic Evaluation
No other documentation is needed
Please sign second page

OR

☐ Sleep Clinic Evaluation **after** sleep study
(See below)

SLEEP STUDY – PLEASE CHECK ONE OF THE FOLLOWING:

Polysomnography

☐ Standard Polysomnogram*
(on room air unless specified)

☐ CPAP titration

☐ CPAP/Bilevel study (Pressure = _____)

☐ Other, please specify:
_____

Special Needs or Instructions:

_____

*I have discussed the procedure of a sleep study and CPAP titration with the patient Yes No

*I would like a CPAP titration study if this baseline study is consistent with sleep apnea Yes No

*** IF THIS IS A DIRECT REFERRAL FOR A SLEEP STUDY, A HISTORY AND*** PHYSICAL EXAM DOCUMENT IS REQUIRED FOR SLEEP STUDY.

*** PLEASE NOTE, THESE ORDERS EXPIRE 6 MONTHS FROM DATE OF SIGNATURE ***

REMINDERS:

1. Please let your patient know that you are requesting a sleep disorder evaluation or a sleep study.
2. Titration studies will NOT be scheduled until patient has had an evaluation in sleep clinic.
3. Medicare patients: for sleep study, clinic note MUST contain indication for study and a detailed sleep history. Physical exam (neuro, ENT, CV, weight, and VS), and functional limitations related to sleep disturbance ***If this is not included, a sleep clinic appointment will be scheduled first.***

Revised 12/9/10

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Pertinent History:

Is the patient under treatment for hypertension?	Yes	No	Unknown
Has the patient ever had congestive heart failure?	Yes	No	Unknown
Does the patient have pulmonary hypertension?	Yes	No	Unknown

Check all that apply:

- ☐ Witnessed apneas during sleep
- ☐ Awakens with choking or gasping sensation
- ☐ Disruptive Snoring
- ☐ Daytime Sleepiness
- ☐ MVA or close call from falling asleep at wheel
- ☐ Tired in morning after sleep at night
- ☐ Awakens with a headache
- ☐ History of PTSD
- ☐ Weight changed >1 lbs in the past year
- ☐ Frequent nocturnal awakenings to urinate
- ☐ Hypnagogic/hypnapompic hallucinations
- ☐ Sleep paralysis
- ☐ Cataplexy
- ☐ Hx or narcolepsy
- ☐ Hx restless legs
- ☐ Hx of fibromyalgia

Complete only if patient has already been diagnosed with sleep apnea:

When diagnosed with OSA: _____

Patient currently on CPAP or BPAP Yes No Pressure settings: _____

Any other treatment for sleep apnea? If yes, what? Yes No _____

Any prior Sleep Studies? If yes, provide study date(s) and results: _____

_____

Other Pertinent History: _____

_____

Pertinent Physical Exam Findings (BP, upper airway, lung/cardiac exam):

Blood Pressure: _____ Respirations: _____ Height: _____ Weight: _____

Nose: WNL; Other: _____

Throat: WNL; Other: _____

Pharynx: WNL; Other: _____

Cardiovascular Exam: WNL; Other: _____

Neurological Exam: WNL; Other: _____

MD Signature ***(Required)*** Date

MD Printed Name

REMINDER: (Be sure to indicate on page 1 whether patient should come first to clinic or lab) **Revised 12/6/10**

Revised 12/9/10