

Patient Information:

Name:		Male or Female:	Height/Weight:
Street Address:			DOB:
City:		State:	Zip:
Home phone:	Work phone:	Mobile phone:	

Diagnosis:

<input type="checkbox"/> Sleep Apnea 780.53 / 327.23	<input type="checkbox"/> Daytime Sleepiness 780.54	<input type="checkbox"/> Insomnia 780.51	<input type="checkbox"/> Periodic Limb Movements 327.51
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Please perform the following procedures:

<input type="checkbox"/> Diagnostic Polysomnogram	<input type="checkbox"/> Split Night Polysomnogram <i>(Diagnostic w/Treatment)</i>	<input type="checkbox"/> CPAP/Bi-level Titration
<input type="checkbox"/> PSG w/Multiple Sleep Latency Test	<input type="checkbox"/> Re-evaluate for CPAP/Bi-level	<input type="checkbox"/> Daytime Desensitization
		<input type="checkbox"/> Consult with Sleep Specialist

Consultations with providers with an interest in sleep:

<input type="checkbox"/> Daniel Loube, MD DABSM, Pulmonologist	<input type="checkbox"/> Darryk Barlow, MD ENT SE Portland	<input type="checkbox"/> Rich Moore, DDS Dental (Oral) Appliance
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Patient history, symptoms:

<input type="checkbox"/> Loud Snoring	<input type="checkbox"/> Witnessed Apnea	<input type="checkbox"/> Daytime Sleepiness	<input type="checkbox"/> Morning Headache
<input type="checkbox"/> Cardiovascular disease	<input type="checkbox"/> Trouble Falling Asleep	<input type="checkbox"/> Fatigue (chronic?)	<input type="checkbox"/> Asthma
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Trouble Staying Asleep	<input type="checkbox"/> Restless Sleep/Legs	<input type="checkbox"/> COPD
<input type="checkbox"/> Use of Hypnotic RX	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Morbid Obesity	<input type="checkbox"/> Depression/Anxiety

Prior History of Sleep Apnea: O Yes O No	If yes date of study & RDI or AHI	If yes, current pressure:
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Prescribing Provider Information

Provider Name:	NPI:
Clinic Name:	Contact:
Street Address:	Suite:
City, State, Zip:	
Phone:	Fax:

Please fax to (503) 652-0068 including a copy of the front/back of patient's insurance ID card(s), patient demographics, and chart notes documenting sleep-related issues. Thank you for using Sleepwell!

Provider Signature: _____ Today's Date: _____