

**Patient Information:**

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

**Diagnosis:**

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

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

**Consultations with providers with an interest in sleep:**

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

<input type="radio"/> Loud Snoring	<input type="radio"/> Witnessed Apnea	<input type="radio"/> Daytime Sleepiness	<input type="radio"/> Morning Headache
<input type="radio"/> Cardiovascular disease	<input type="radio"/> Trouble Falling Asleep	<input type="radio"/> Fatigue (chronic?)	<input type="radio"/> Asthma
<input type="radio"/> Hypertension	<input type="radio"/> Trouble Staying Asleep	<input type="radio"/> Restless Sleep/Legs	<input type="radio"/> COPD
<input type="radio"/> Use of Hypnotic RX	<input type="radio"/> Diabetes	<input type="radio"/> Morbid Obesity	<input type="radio"/> Depression/Anxiety
Prior History of Sleep Apnea: O Yes    O No	If yes date of study & RDI or AHI	If yes, current pressure:	

**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: \_\_\_\_\_