Rhode Island Hospital
Lifespan. Delivering health with care.®

Adult Polysomnography (Sleep Study) Request Form
Lifespan Sleep Disorders Center
Scheduling: 401-431-5420 • Fax: 401-431-5429

MR # _____

Patient Information

PATIENT NAME _____ SEX M ☐ F ☐

DOB _____ /_____ / _____ SOCIAL SECURITY NUMBER _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

ORDERING PHYSICIAN _____ DATE _____

PRINT NAME _____ SIGNATURE _____

PRIMARY PHYSICIAN _____ AUTHORIZATION # _____

VALID AUTHORIZATION DATES _____

Insurance Information

PRIMARY INSURANCE _____

POLICY # _____ GROUP # _____

INSURANCE TELEPHONE _____

POLICY HOLDER NAME _____

RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE _____

POLICY # _____ GROUP # _____

INSURANCE TELEPHONE _____

POLICY HOLDER NAME _____

RELATIONSHIP TO PATIENT _____

Diagnosis	Primary	2	3	Patient's Normal Bedtime/Normal Wake-Up Time:
Supplemental O2 Needed	Yes	No	Amount	Late sleeper?
Necessity of Study	Elective	Urgent	Emergent	Comment/special needs:

Tests/Procedures (Check all that apply and enter ICD-10 diagnosis code for each test ordered)

√	Test	ICD-10	√	Test	ICD-10
	Baseline Study			CPAP Titration	
	½ Baseline and ½ CPAP			Bilevel Titration Spontaneous	
	½ Baseline and ½ Bilevel			Efficacy PAP with set pressure at _____ cm H2O	
	Dental Appliance Titration			Multiple Sleep Latency Test or Maintenance of Wakefulness Test	
	Other: (Specify):			Special Instructions:	

Would you like your patient to be seen in follow-up by a sleep physician? Y ☐ N ☐ Preference? _____

HAS PATIENT BEEN GIVEN INFORMATION PACKET? Y ☐ N ☐

DATE OF STUDY _____ TIME _____ HASBRO _____ EP _____ EG _____

FOLLOW-UP VISIT _____ DATE _____ TIME _____ LOCATION _____

PLEASE BE ADVISED THAT SLEEP STUDY RESULTS TAKE 2 WEEKS TO BE GENERATED

Lifespan Sleep Disorders Center
Sleep History, Medication, Epworth Sleepiness Scale

PATIENT NAME _____ DOB _____ /_____ / _____

Please fill out this sheet. It is imperative that this information be completed so we can ensure that the correct test is done, and a concise interpretation of the results may be made. Please provide all previous sleep studies.

PATIENT'S HEIGHT _____ inches PATIENT'S WEIGHT _____ lbs

Sleep History (Check all that apply)					
	Loud snoring		Insomnia		Cataplexy
	Choking arousals		Fragmented sleep		Sleep Paralysis
	Observed apneas during sleep		Restless leg symptoms		Hypnagogic hallucinations
	Daytime sleepiness		Sleepwalking		Circadian rhythm problems
	Nocturia		Dream Enactment		Other

Major Medical Problems (Check all that apply)					
	Known OSA		COPD		Migraines or chronic headaches
	Diabetes mellitus		Asthma		Fibromyalgia or chronic pain
	CAD		Anemia		Anxiety
	Hypertension		Hypothyroidism		Depression
	CHF		GERD		Bipolar disorder
	Arrhythmias Type _____		Pulmonary Hypertension		Seizure disorder
	Cerebrovascular Disease		Renal failure		Other _____

Medications: (fill in or attach list) _____

_____

Oxygen: Unless approved by a Sleep Center physician, all baseline studies will be done on room air, to allow for better interpretation of the results. Specify O2 flow if medically necessary. _____ LPM

Epworth Sleepiness Scale: Please ask your patient questions using the scale to choose the most appropriate number for each situation:

0 = Would never doze or sleep
1 = Slight chance of dozing or sleeping
2 = Moderate chance of dozing or sleeping
3 = High chance of dozing or sleeping

Situation Chance of Dozing or Sleeping	Score
Sitting and reading	
Watching TV	
Sitting inactive in a public place	
Being a passenger in a motor vehicle for an hour or more	
Lying down in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch (no alcohol)	
Stopped for a few minutes in traffic while driving	
Total Score	

PHYSICIAN NAME _____

PHYSICIAN SIGNATURE _____

PHONE _____ FAX _____ DATE _____

How May We Help You?

Please inform us of any needs or equipment that you may require so we can better accommodate you during your study. Please call 401-431-5420. Thank you.

Please inform us if you have any of the following:

- Oxygen at night? _____ Liters of oxygen _____
- Trach tube (Please bring **all** connections, humidification, and suction equipment etc.)
- Ventilator (Please bring **all** connections, humidification, and suction equipment etc.)

Do you need:

- Translator _____ Spanish _____ Other _____

Physical assistance with:

- Getting in and out of bed
- Help in the bathroom
- Walking/ mobilization
- Room close to bathroom
- Other needs not listed _____

Equipment:

- Cpap/bipap mask (Please bring mask and head gear only)
- Side rails
- Urinal or bedpan
- Wheelchair
- Hoyer lift
- Suction equipment (Please bring)
- Ventilator (Please bring all connections, humidification, and suction equipment etc.)
- Other equipment not listed _____

Accommodations:

- Pull out bed for caregiver
- Bed rails
- Attendant or nursing assistant
- Other items not listed _____