Sleep Study Request
Physician Order Form/Prescription

101 Tara Commons Drive
Loganville, GA 30052
Phone: 678-928-9700 / Fax: 770-466-1585
www.waltonpulmonary.com

First Name ______________________________ **Last Name** _______________________________

Phone Type 1 ____________________________ **Phone Number** ____________________________

Phone Type 2 ____________________________ **Phone Number** ____________________________

Along with this form, please send the following to fax # 770-466-1585:
1) Latest office notes, 2) Patient demographics, 3) Copy of insurance card(s), front and back, 4) previous sleep study report, if applicable

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Service requested

Suspected Diagnosis

Symptoms

- Snoring
- Witnessed breathing pauses
- Unrefreshed sleep
- Morning headaches
- Irritability
- Depression and anxiety
- Abnormal limb movement at night
- Sleep walking
- Lack of energy
- Excessive daytime sleepiness
- Needs to take daytime naps

Commorbid conditions

- COPD
- Hypoxemia on oxygen
- Congestive heart failure
- Hypertension
- Diabetes
- Atrial fibrillation
- Coronary artery disease
- History of CVA
- Seizure disorder

Contraindications to Home Sleep Study

Neck Size ______ **Epworth** ______ **Height** ______ **Weight** ______ **Blood Pressure** ______ **HR** ______ **BMI** ______

I have evaluated the above patient in my office for sleep disturbances, and I have concluded that a sleep study is medically necessary for this patient, based on the enclosed patient history and physical examination findings.

Requesting Physician's Name: _______________________________ **Phone Number**: ________________________

Physician Signature: _______________________________________ **Date**: _________________________________

We thank you for your referral!