Atoka
340 Atoka McLaughlin Dr.
Suite C
Atoka, TN 38004
Ph: (901) 840-1084

Polysomnography Medical Request Form

Date: **Fax: (901) 837-0183**

Patient Name: ______________________ DOB: ___/___/___ SSN: ______________________ ☐ Male ☐ Female

Address: ______________________________________ City: ________________ State: ____ Zip: ________

Home Phone: ____________________ Work Phone: _______________ Cell Phone: ______________________

Emergency Contact: __________________ Relationship: _________________ Phone: ____________________

Suspected Diagnosis (Check appropriate boxes)

☐ Obstructive Sleep Apnea (OSA)
☐ Narcolepsy
☐ Restless Legs/Periodic Limb Movement Disorder
☐ Morbid Obesity
☐ REM Behavior Disorder
☐ Seizures
☐ Hypersomnia
☐ Other (specify) ______________________________

Sleep History/Symptoms (Check appropriate boxes)

☐ Excessive daytime sleepiness
☐ Witnessed apneas
☐ Difficulty initiating sleep
☐ Morning headaches
☐ Nocturnal teeth grinding
☐ Snoring
☐ Insomnia
☐ Sleepwalking
☐ Acting out dreams
☐ Muscle/joint aches
☐ Depression
☐ Cataplexy/Narcolepsy
☐ Sleep paralysis
☐ Leg movements
☐ Wakes up choking
☐ Frequent nightmares
☐ S/p surgery for OSA/T&A

Relevant Medical History (Check appropriate boxes)

☐ Hypertension
☐ Pulmonary hypertension
☐ Pulmonary disease
☐ Arrhythmia (VT/Afib)
☐ CHF
☐ CAD
☐ Diabetes mellitus
☐ Fibromyalgia
☐ Stroke
☐ Thyroid disease
☐ Claustrophobic
☐ Latex allergies
☐ Hiatal hernia
☐ Anxiety disorder
☐ Other

Previous Sleep Study? Yes / No

If yes, where? ____________________ when? ____________________

Studies Requested (Check appropriate boxes)

☐ Overnight Polysomnography
☐ Positive Airway Pressure (CPAP) Titration
☐ Combined Overnight Polysomnography and CPAP Titration (Split Night Study); subject to meeting testing criteria
☐ Maintenance of Wakefulness Test (MWT)
☐ Narcolepsy Screen (Overnight Polysomnography followed by MSLT)
☐ EEG Monitoring (Suspected Seizure Disorder)

Supplemental oxygen will be administered when indicated and as referring physician, you will be notified.

Physician name: ____________________ UPIN#: __________________ Signature: ____________________

Specialty: ☐ Pulmonary ☐ Neurology ☐ ENT ☐ Cardiology ☐ Internal Medicine ☐ Family Practice Other (please specify) __________

Address: ______________________________________ Email: ____________________

City: ________________ State: ______ Zip: ________ Contact Person: ____________________

Phone: ______________________________ Fax: ______________________________

PLEASE ATTACH/FAX PATIENT DEMOGRAPHICS **(Include insurance card and brief H&P relating to the possible sleep disorder)**