



Phone: (888) 497-5337 Ext. 114 Fax: (866) 348-1398

Sleep Intake Form **MOST RECENT OFFICE/CLINICAL NOTES REQUIRED**

The following Sleep Intake form must be completed by all physicians ordering sleep testing procedures.

Patient Name: _____ Insurance ID# : _____ DOB: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Physician: _____ Group: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax #: _____

Reason for referral: _____

I. MINIMUM SLEEP STUDY CRITERIA FOR HST

Must document at least one of the following:

A. Chief Complaint(s):

- Disruptive snoring EDS Disturbed or restless sleep Non-restorative sleep

(AND must document at least two of following)

B. Chief Symptom(s):

- Witnessed apnea events, choking or gasping Unexplained hypertension or arrhythmia

_____ [BMI ≥ 30] **Height:** _____ **Weight:** _____

- Frequent unexplained arousals _____ [ESS ≥ 10] Non-ambulatory

(AND must be at least ≥ one month duration)

C. Symptom Duration:

- < one month ≥ one month ≥ three months ≥ six months

II. MINIMUM CRITERIA FOR NPSG

Must satisfy above criteria for HST AND must document one of following:

A. Chief Symptom(s):

- Pulmonary hypertension COPD CHF CAH Other (specify) _____

- Nocturnal seizures Neuromuscular weakness Other Sleep Disorder (specify)

- Cmplx SDB Neurodegenerative Disorders Disruptive sleep behavior (specify)

(AND must be at least ≥ one month duration)

- B. CoMorbid Dx Duration:** < one month ≥ one month ≥ three months ≥ six months



DEFINITIONS: HST=home sleep study; NPSG=in lab polysomnogram; EDS=excessive daytime Sleepiness; ESS=Epworth Sleepiness Scale; BMI= body mass index; CHF=Congestive Heart Failure; COPD=Chronic Obstructive Pulmonary Disease; CMPLX SDB=Complex Sleep Disordered Breathing; CAH=Central Alveolar Hypoventilation; MSLT=multiple sleep latency test; MWT=maintenance of wakefulness test.

Current List of Medications (if not on clinical notes):

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you.

Use the following 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

- 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 equals your ESS _____

0-9 – Average score, normal population

If a Facility Based Study is approved, do you have preference for a contracted PEIA Sleep Lab? Please make your request below. Please note, the listing of a facility does not guarantee site selection:

- 1) _____
- 2) _____