Richmond University Medical Center

355 Bard Ave, Staten Island, NY 10310
t: (718)818-2547 f:(718)818-1298

PATIENT INFORMATION

PATIENT NAME _____ DATE OF BIRTH ___/___/___

ADDRESS _____

HOME _____ MOBILE _____ WORK _____

INSURANCE CARRIER _____ ID NUMBER _____

TYPE OF VISIT / TEST REQUESTED

- ☐ Unattended In-Home Testing
  (for R/O OSA only & pending insurance approval)
- ☐ Split Night
- ☐ Multiple Sleep Latency Test
- ☐ Maintenance of Wakefulness Test (MWT)
- ☐ Nocturnal Polysomnogram
- ☐ Nasal CPAP Titration

Please send all provider notes with your sleep study request

PATIENT REFERRED TO RULE OUT OR CONFIRM THE FOLLOWING

- ☐ Sleep Apnea
- ☐ Daytime Sleepiness
- ☐ Periodic Limb Movement Disorder
- ☐ Insomnia
- ☐ Restless Legs
- ☐ Narcolepsy
- ☐ Other _____

PATIENT HISTORY

Snoring..... ☐ Yes ☐ No
Gasping or choking during sleep..... ☐ Yes ☐ No
Apneic events witnessed by bed partner..... ☐ Yes ☐ No
Discomfort or restlessness of lower limbs before or during the sleep period..... ☐ Yes ☐ No
Twitching, jerking, or kicking of lower limbs before or during the sleep period..... ☐ Yes ☐ No
Daytime sleepiness or fatigue..... ☐ Yes ☐ No
Previous diagnosis of OSA?..... ☐ Yes ☐ No
If yes, is patient on CPAP?..... ☐ Yes ☐ No
If on CPAP, at what pressure?..... _____
Has upper airway surgery been performed?..... ☐ Yes ☐ No
Is this request for a sleep study for pre-operative evaluation prior to bariatric surgery?..... ☐ Yes ☐ No

To help with scheduling, when do you plan to have a follow-up appointment with this patient? _____

Height _____ ft. _____ in. Weight _____ lbs. Blood Pressure _____ /_____

Medical Conditions (include recent surgeries) _____

Current Medications _____

Allergies _____

Is the patient a commercial driver?..... ☐ Yes ☐ No

Is assistance required for language translation, ambulation, toileting, or other activities? If yes, please explain: _____

REFERRING PHYSICIAN

NAME _____ TELEPHONE _____

SPECIALTY _____ REFERRAL DATE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ NPI# _____

SIGNATURE _____ FAX _____ E-MAIL _____

REPORT PREFERENCES

- ☐ Call with test results prior to issuance of report

Send report by ☐ Mail ☐ Fax