

THE SLEEP CENTER

At Cypress Fairbanks Medical Center

TEST REQUEST ORDER FORM



Please call 281.897.3121 to schedule or visit us online at www.cyfairhospital.com to pre-register your sleep study. Insurance pre-authorization may be required prior to the sleep study, and every effort will be made to schedule your appointment as soon as possible.

Thank You for your referral.

Date: _____

FROM

Dr. _____ Phone: _____ Fax: _____

Diagnosis / Sleep Disorder:	<input type="checkbox"/> Snoring	<input type="checkbox"/> Witnessed Apnea	<input type="checkbox"/> Excessive Daytime Sleepiness	<input type="checkbox"/> Nocturnal Seizures
	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Respiratory Distr. While Asleep	<input type="checkbox"/> Obstructive Sleep Apnea	<input type="checkbox"/> Nocturnal Panic Attacks
	<input type="checkbox"/> Chronic Fatigue	<input type="checkbox"/> Shift-Work Disorder	<input type="checkbox"/> Repetitive Movements	<input type="checkbox"/> Post-OP T&A - Septoplasty - UPPP - Turbinectomy - Date of Surg. _____

CHECK STUDIES DESIRED

- NOCTURNAL POLYSOMNOGRAPHY (NPSG) – Diagnostic sleep study. Commonly recommended for first time evaluation.
- CPAP TRIAL – Therapeutic titration of CPAP. Recommended for patients with documented sleep breathing disorders after NPSG
- SPLIT NIGHT STUDY – Diagnostic sleep study and CPAP titration in second part of study, if the patient has enough respiratory events in first part of study. Commonly recommended for high suspicion of OSA. (Note: Those patients without enough respiratory events in the first part of the study will not qualify for a "Split Night Study", and may require a second night titration study.)
- MULTIPLE SLEEP LATENCY TEST (MSLT) – A daytime study to quantify the degree of sleepiness in a patient, or to determine specific characteristics consistent with Narcolepsy.
- MAINTAINING OF WAKEFULNESS TEST (MWT) – Recommended to determine the adequacy of the treatment.

PATIENT INFORMATION

Name: _____ Hm. Phone: _____ Wk. Phone: _____

Insurance Information: _____

DOB: _____ Sex: M F

Please FAX copies of the patient's insurance information. This should include front and back portions of their insurance I.D. card.

Previous Sleep Studies? Yes No If Yes, Where _____ When _____

Please send a copy of the report.

INSTRUCTIONS

Please include a copy of the patient's history and physical

****PHYSICIAN SIGNATURE:** _____

FAX 281.517.4700

PATIENT ID

10655 Steepletop Dr., Houston, TX 77065
Scheduling Phone: 281.897.3121 Sleep Phone: 281.897.3366