UNIVERSITY of MARYLAND SHORE REGIONAL HEALTH
SLEEP DISORDERS CENTER

UM SHORE MEDICAL CENTER AT EASTON
219 S. Washington Street
Easton, MD 21601

UM SHORE MEDICAL PAVILION
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Queenstown, MD 21658

UM SHORE MEDICAL CENTER AT DORCHESTER
300 Byrn Street
Cambridge, MD 21613

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www.umshoreregional.org/programs/sleep

SLEEP STUDY REQUEST FORM

*Please **COMPLETE** this form (**to be completed by referring physician**) and send/fax **demographic** information with **MOST RECENT OFFICE NOTES** to (410) 763-7051*

PATIENT INFORMATION:

Name: _____ Birth Date: _____ Best Contact #: _____

Primary Care Physician: _____ Gender: M / F Height: _____ Weight: _____ Neck Size: _____

Select the following that apply: ❑ DOT Certification ❑ Pre-Op Testing Employment Hours: ❑ Day ❑ Overnight

STUDY REQUESTED:

❑ Standard Diagnostic PSG Study *(Conversion to Split-night per protocol for AHI>40 is standard; if PSG is denied by insurance, Home Sleep Test will be substituted, if applicable)*

❑ Pediatric (<12 *Must have scheduled pre-study visit to sleep lab)*

❑ Other: _____

FOLLOW UP:

❑ Schedule follow-up consultation with sleep specialist to review the results with patient.

❑ DO NOT schedule a follow-up. Ordering doctor will review results with patient.

RELEVANT MEDICAL HISTORY (Must fax most recent history and physical for approval):

Existing Conditions: ❑ Seizures D.O ❑ Anxiety ❑ Smoking ❑ GERD ❑ CHF
❑ Hypertension ❑ AFIB/ Arrhythmias ❑ Depression ❑ COPD ❑ Asthma ❑ Diabetes
❑ Obesity ❑ Coronary artery disease ❑ *Other*: _____

Primary Symptoms: ❑ Large Neck ❑ Sleep Paralysis ❑ Cataplexy
❑ Witnessed Apneas ❑ Frequent snoring ❑ Excessive daytime sleepiness ❑ Nocturia
❑ Choking ❑ Irregular Breathing ❑ Headaches ❑ Nocturnal Dyspnea
❑ Difficulty falling asleep ❑ Hypnogogic Hallucinations ❑ Automatic Behavior ❑ Frequent leg movements
❑ Repetitive Violent or Injurious Behavior

Special Needs: ❑ Nocturnal Oxygen ____LPM ❑ Urinary / Stool Incontinence ❑ Medications
❑ Interpreter ❑ *Other*: _____

SUSPECTED DISORDERS (Check all that apply)

❑ Obstructive Sleep Apnea ❑ Central Apnea ❑ Chronic Respiratory Failure
❑ Periodic Limb Movements ❑ Narcolepsy ❑ Parasomnias Behavior (e.g. sleepwalking, RBD, bruxism etc)

REFERRING PHYSICIAN INFORMATION (REQUIRED)**:**

Ordering Physician/Practitioner: _____ Date: _____

Phone: _____ Fax: _____

Physician Signature: _____ UPIN: _____

Approval by RSDC Medical Director: _____ Date: _____ Time: _____