Midwest Sleep Diagnostics

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ORDER FOR TESTING

INSTRUCTIONS: This form is provided for your convenience in ordering sleep studies. Our staff will handle pre-certification requirements as a courtesy to you. It is not necessary to fill this form out completely, but required information is marked with an asterisk (*). Fax this form to 636-227-8610.

*PATIENT:		TITLE:	Mr.
SOCIAL SECURITY #:		DATE OF BIRTH:	
HEIGHT:	feet inches	WEIGHT:	
ADDRESS:		ZIP CODE:	
CITY, STATE:		CELL PHONE #:	
*HOME PHONE #:		WORK PHONE #:	
INSURANCE COMPANY:		TELEPHONE #:	
PLAN OR CONTRACT #:		GROUP #:	

TYPE OF STUDY :

- ☐ ALL TESTING (as appropriate)

OR SPECIFY:

- ☐ SPLIT NIGHT POLYSOMNOGRAPHY (for apnea)
- ☐ DIAGNOSTIC POLYSOMNOGRAPHY
- ☐ MULTIPLE SLEEP LATENCY TEST (MSLT)
- ☐ MAINTENANCE OF WAKEFULNESS TEST (MWT)
- ☐ NASAL CPAP TITRATION
- ☐ NASAL CPAP DEVICE

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PRESENTING SYMPTOMS :

- ☐ Snoring
- ☐ Excessive Daytime Sleepiness
- ☐ Witnessed Apneas
- ☐ Hypertension
- ☐ Headaches
- ☐ Restless Sleep
- ☐ Insomnia
- ☐ Limb movement in sleep
- ☐ Sleep-walking

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SPECIAL CONCERNS:	*Please include here any special conditions or instructions for this patient.* ***If a previous sleep study was performed, please include a copy of the report or list when and where performed.***

*PHYSICIAN'S PRINTED NAME:		SENT BY:	
*PHYSICIAN SIGNATURE:		DATE:	06/29/2009

Rev. 002

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