WINCHESTER HOSPITAL
Winchester, Massachusetts
Sleep Disorders Center
Baldwin Park I, Suite 110
12 Alfred Street, Woburn, MA 01801
Phone: 781-756-2325 Fax: 781-756-7045

SLEEP EVALUATION FORM

PATIENT INFORMATION

Name _____ DOB _____ MR# _____

Home Phone _____ Work/Cell Phone _____

Primary Physician _____ Requesting Physician _____

If sleep consult desired prior to sleep study, please contact one of the sleep physician listed below directly.

PATIENT IS BEING REFERRED FOR:

Sleep Study Only

Results sent to referring physician for further management.

☐ **Diagnostic Sleep Study**
Full night polysomnography (PSG). **If patient meets AASM criteria, CPAP may be started.**

☐ *If Diagnostic study only is requested, please check here.
Reason _____

☐ **CPAP or BIPAP Titration/Retitration**
Titration for patients with OSA documented by prior PSG.

☐ *** Diagnostic Sleep Study with Multiple Sleep Latency Test (MSLT) or Maintenance of Wakefulness Test (MWT).** Diagnostic sleep study followed by a daytime nap test to diagnose narcolepsy or excessive daytime sleepiness.
*** Both studies must be ordered by a neurologist, pulmonologist or sleep physician.**

☐ **If PSG is abnormal, consultation with interpreting physician is requested for evaluation and management.**

Please initial if this is desired _____

Is patient going to be seen or has patient been seen in the past by one of the following:

***Please choose Sleep Reader/Consultant below**

☐ Albanese ☐ Patwa
☐ Bader ☐ Taylor
☐ Chervin ☐ Zaslow
☐ Gebhardt

☐ *No Preference - reading MD through rotation

MEDICAL HISTORY (history and physical examination is required). Please fax office notes/progress notes with request.

Weight _____ lbs. Height _____ BMI _____ Neck Size _____ in.

Suspected Disorder(s)
- ☐ Obstructive Sleep Apnea (OSA)
- ☐ Narcolepsy
- ☐ Nocturnal Seizures/Parasomnias
- ☐ Insomnia
- ☐ Restless legs syndrome (RLS) or periodic limb movements of sleep (PLMS)

Primary Symptoms
- ☐ Snoring/gasping/choking
- ☐ Witnessed apnea
- ☐ Obese/large neck
- ☐ Daytime sleepiness
- ☐ Difficulty falling asleep
- ☐ Fragmented sleep
- ☐ Frequent leg movements during sleep
- ☐ Preoperative assessment

Special Needs
- ☐ Nocturnal O2 - Level: _____
- ☐ Wheelchair
- ☐ Currently using PAP -
- ☐ Pressure (cm): _____
- ☐ Other: _____

Medications/comments _____

_____

Please Circle
PMH: HTN DM COPD CAD CHF Depression Other

Physician's Signature _____ **Date/Time** _____