METHODIST RICHARDSON MEDICAL CENTER
SLEEP DISORDERS CENTER
ORDER FORM

Fax: 469-204-0273 | Phone: 469-204-0271

*****PLEASE FILL IN COMPLETELY OR PROVIDE DOCUMENTATION WITH YOUR FAX*****

PATIENT INFORMATION

Patient's Name	DOB ☐ M ☐ F
Address	City, State, Zip
Home Phone Cell Phone	Email Address

REFERRING PHYSICIAN INFORMATION

Referring Physician's Name	Specialty
Street Address	Phone Number Fax Number
City, State, Zip	NPI #
Patient's PCP Name:	Phone Number Fax Number

INSURANCE INFORMATION

Insurance Provider	Benefits Phone Number
Policy Number Group Number	Insured's Name

CLINICAL DIAGNOSIS mark ALL that apply

- ☐ **G47.30 Obstructive Sleep Apnea - Unspecified**
- ☐ **G47.10 Hypersomnia**
- ☐ **Narcolepsy**
- ☐ **G47.61 Periodic Limb Movements during sleep**
- ☐ **G25.81 Restless Leg Syndrome**
- ☐ **Other:** ___________________________________

OBSERVATIONS/INDICATIONS mark ALL that apply

☐ Hypersomnolence ☐ Loud or Disruptive Snoring ☐ Fatigue ☐ Obesity ☐ HTN/ASHD

☐ Witnessed Apnea ☐ AM headaches ☐ Leg pain/jerking

☐ Other ____

Previous Sleep Study: ☐ Yes Date:______________ ☐ No

Currently on CPAP: ☐ Yes ☐ No

Please check if this study is to Qualify for: ☐ oxygen therapy on CPAP for Medicare ☐ BiPAP therapy *if appropriate*

REFERRAL OPTIONS

A. Diagnostic Study Types *(check all that apply)*:

- ☐ **PSG w/ PAP titration** if OSA found *(A SPLIT night protocol will be followed when AASM criteria met and clinically appropriate).*
- ☐ **HOME** Sleep Test **(HST)** with PAP titration if OSA is found
- ☐ **PSG**/Diagnostic Study Only
- ☐ **PAP Titration** Study Only
- ☐ **HOME** Sleep Test **(HST)** Only
- ☐ **MSLT** Daytime Study
- ☐ **MWT** Daytime Study

B. Consult/Follow Up Options

- ☐ **Pre Test Sleep Medicine Consultation**
- ☐ **Post Test Sleep Medicine Consultation** if OSA is found.
- ☐ **No Sleep Medicine Consultation** *(ordering Physician initiates therapy and manages follow up)*

Select Consulting Physcian:

☐ Gregory Foster, M.D.

☐ R. Bruce Gammon, M.D. ☐ Rashid Rahman, M.D.

C. Other/Instructions:

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Ordering Physician's Signature (Required):___________________________________ ***DATE:***___________

Sleep Disorders Center
401 W. Campbell Rd. Ste. 210
Richardson, TX 75080

Gregory Foster, M.D., Medical Director
2821 E. President George Bush Tpke. Ste. 407
Richardson, TX 75082