



Sleep Disorders Clinical Evaluation Form

Date ____/____/____

A) PATIENT INFORMATION:

Patient Name (please Print) _____ Date of Birth ____/____/____

Home Telephone _____ Work Telephone _____ Cell _____

Primary Insurance ID _____ Primary Care Authorization ID (if ness) _____

B) CLINICAL INFORMATION (Please check all that apply)

1. Primary Sleep Disorder Features*

- | | |
|---|--|
| <input type="checkbox"/> snoring | <input type="checkbox"/> witnessed sleep disordered breathing |
| <input type="checkbox"/> restless extremity sensations | <input type="checkbox"/> abnormal extremity movements during sleep |
| <input type="checkbox"/> excessive daytime sleepiness | <input type="checkbox"/> weakness attacks, emotionally precipitated |
| <input type="checkbox"/> sleep onset insomnia | <input type="checkbox"/> sleep maintenance insomnia |
| <input type="checkbox"/> violent behaviors during sleep | <input type="checkbox"/> sleep timing, possible circadian, sleep disturbance |
| <input type="checkbox"/> other sleep-associated phenomena. Please describe: _____ | |

2. Medical History*

- | | |
|--|---|
| <input type="checkbox"/> hypertension | <input type="checkbox"/> obesity |
| <input type="checkbox"/> coronary artery disease | <input type="checkbox"/> congestive heart failure |
| <input type="checkbox"/> cerebrovascular disease | <input type="checkbox"/> cardiac arrhythmia |
| <input type="checkbox"/> seizures/ Epilepsy | <input type="checkbox"/> diabetes mellitus |
| <input type="checkbox"/> asthma/COPD | <input type="checkbox"/> neuromuscular disease |

3. Physical Examination

Blood Pressure ____/____ Height ____ ft ____ in Weight ____ Lbs

Check which of the following are within normal limits. **If abnormal**, please describe:

- | | | | |
|---|-------------------|----------------------------------|-------------------|
| Nasal Passages <input type="checkbox"/> | Description _____ | Chest <input type="checkbox"/> | Description _____ |
| Oropharynx <input type="checkbox"/> | Description _____ | Abdomen <input type="checkbox"/> | Description _____ |
| Neck <input type="checkbox"/> | Description _____ | Other <input type="checkbox"/> | Description _____ |
| Cardiac <input type="checkbox"/> | Description _____ | | |

5. Medications* (including the over-the-counter agents if known)

6. Allergies: Medications _____ Contact Allergies _____

7. Other Sleep Disorders Previous Sleep Study (include copy) Current CPAP level ____ Bi-level Ipap/Epap _____ cm/H2O

C) PHYSICIAN SERVICES: Please choose from the following services (check all that Apply)

- | | |
|---|--|
| <input type="checkbox"/> Sleep Disorders Consultation | <input type="checkbox"/> Multiple Sleep Latency Test (MSLT) |
| <input type="checkbox"/> Nocturnal Polysomnography (sleep study) | <input type="checkbox"/> Maintenance of Wakefulness Test (MWT) |
| <input type="checkbox"/> CPAP/Bi-level Titration only (Include copy of sleep study) | <input type="checkbox"/> CPAP Equipment Evaluation (PSP patients only) |
| <input type="checkbox"/> Diagnostic/Therapeutic PSG (Split night sleep study) | <input type="checkbox"/> Free Sleep Apnea Pre- Screening |

D) REFERRAL SOURCE:

Clinician Name _____

Office Telephone _____ Office Fax _____

Please Feel Free to use this evaluation as a referral form to **Pacific Sleep Program.**

2120 Exchange St #302, Astoria, OR. (Tel) 503.325.3126 (Fax) 503.325.4933