

Sleep Disorders Clinical Evaluation Form

DATE ____/____/____



Pacific Sleep Program

Setting the standard in sleep medicine
for over 25 years

A) PATIENT INFORMATION

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

Home Telephone _____ Work Telephone _____ Cell _____

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

B) CLINICAL INFORMATION (Please check all that apply) *Indicates Required Field

1. Primary Sleep Disorder Features*

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

2. Medical History*

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

3. Physical Examination: * Blood Pressure ____/____ Height ____ ft. ____ in. Weight ____ lbs.

4. 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. Medication Allergies _____ Contact Allergies _____ None7. Other Sleep Disorders: Previous Sleep Study (include copy) Current CPAP level ____ cm/H₂O Bi-Level IPAP ____ EPAP ____ cm/H₂O

8. Please fax most recent Chart Notes if available.

C) PHYSICIAN SERVICES

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

D) REFERRAL SOURCE

Clinician Name: (please print) _____ Clinician Signature _____

Office Telephone _____ Office Fax _____

PLEASE FAX COMPLETED FORM

Portland Fax 503.228.7293 Tel: 503.228.4414

Astoria Fax 503.325.4933 Tel: 503.325.3126