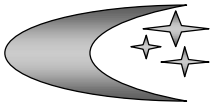

FOUNTAIN VALLEY
REGIONAL SLEEP CENTER, Inc.
"The Path to Healthy Sleep"

SLEEP STUDY (POLYSOMNOGRAM) REQUEST

PATIENT INFORMATION

Patient Name: _____ **DOB:** _____/__/_____

Address: _____

Phone: _____ **SSN#:** ___-___-_____

Medicare#: _____ **Medical#:** _____

Private Insurance: _____ **ID#:** _____

* If sending face sheet this section does not need to be filled out

REASON FOR SLEEP STUDY

- ☐ Insomnia
- ☐ Narcolepsy
- ☐ Sleep Walking
- ☐ Disturbed Sleep
- ☐ Snoring
- ☐ EDS
- ☐ Sleep Talking
- ☐ Other
- ☐ OSA
- ☐ RLS
- ☐ PLM

PATIENT CLINICAL INFORMATION

- ☐ Hypertension
- ☐ Arrhythmia
- ☐ CHF
- ☐ Patient Requires Oxygen flow @ _____ LPM

Current Meds: _____

Known Allergies: _____

STUDY ORDERED

- ☐ Diagnostic Baseline Sleep Study Only (PSG)
- ☐ Split Night/PSG + CPAP
- ☐ PSG + MSLT (MWT)
- ☐ CPAP Titration Only
- ☐ Comment

REFERRING PHYSICIAN INFORMATION

Physician: _____ **UPIN:** _____

Address: _____

Phone: _____ **Fax:** _____ **Contact:** _____

Physician Signature: _____ **Date:** _____

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