THE University of Vermont MEDICAL CENTER

UVM Medical Center Sleep Program
1 South Prospect Street
Phone: (802) 847-5338/ Fax: (802) 847-0379

Adult Order Form, Sleep Medicine

PATIENT INFORMATION
Name: _____
DOB: _____

Our referral process has changed, please read carefully!

Section 1: ORDER FOR SLEEP CONSULTATION *(Sleep specialist will evaluate and order testing and treatment as appropriate)*

If requesting sleep consultation, do not order any sleep tests.

☐ **Ambulatory Sleep consult** (with Physician or APP as appropriate)

☐ **Behavioral Sleep Medicine consult** including Cognitive Behavioral Therapy for Insomnia (with Psychologist)

Reason for consult: _____ (skip to section 3)

Section 2: ORDER FOR SLEEP TESTS *(Ordering provider will manage sleep disorder including PAP management as appropriate)*

☐ **Home Sleep Apnea Test (HSAT)**

☐ **Diagnostic Polysomnogram**: Positive airway pressure (PAP) will NOT be started

☐Using a Mandibular Advancement Device? Dentist _____

☐ **Split-Night Polysomnogram**: Diagnostic test with initiation of PAP therapy if patient meets criteria)

☐ **Therapeutic Polysomnogram (PAP Titration): for patients already diagnosed with sleep disordered breathing**

Polysomnogram Diagnosis of OSA: Year_____ Location_____

(If performed outside of UVMMC, please send copy of report with referral form)

Please discuss PAP with the patient prior to the study if you are ordering a SPLIT or TITRATION study.

Please circle yes or no:

SAFETY (In order to help ensure proper study location and level of assistance)

Yes / No Wheelchair/ cannot walk long distances/needs ADA bathroom
Yes / No Needs assistance with Toileting and/or Transfers in/out of bed or chair
Yes / No Cognitively Impaired
Yes / No Currently Using Nocturnal Oxygen _____LPM

Problem List: (For Insurance Authorization)

Yes / No CAD/HTN/CHF/A-FIB
Yes / No NMD/CVA/Neuro Degenerative Disease
Yes / No COPD/Lung Disease/Pulm HTN
Yes / No Hypercapneic Respiratory Failure

Symptoms

Yes / No Nonrestorative sleep
Yes / No Frequent awakenings
Yes / No Hypoxemia during sleep
Yes / No Unusual behavior during sleep
Yes / No Snoring/Gasping during sleep
Yes / No Observed apnea during sleep
Yes / No Hypersomnolence

Height = _____
Weight =_____
BMI = _____

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Epworth Sleepiness Scale **(Must be completed if ordering a sleep study)**

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the *most appropriate number* for each situation.

0=would *never* doze

1=*slight* chance of dozing

2=*moderate* chance of dozing

3=*high* chance of dozing

Situation	Chance of Dozing
Sitting and reading.	0 1 2 3
Watching TV	0 1 2 3
Sitting, inactive in a public place (i.e.: a theater or a meeting)	0 1 2 3
As a passenger in a car for an hour without a break	0 1 2 3
Lying down to rest in the afternoon when circumstances Permit	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after a lunch without alcohol	0 1 2 3
In a car, while stopped for a few minutes in the traffic	0 1 2 3

Epworth Score _____

For testing to be scheduled we require:

☐ Relevant Office Notes, Problem List, Medication List

☐ Insurance Information

☐ Any prior sleep testing (outside our center)

Section 3: PLEASE SIGN

Date: _____ Provider Signature: _____Ordering Provider: _____(Printed)