



Sleep Medicine Order

CENTRALIZED SCHEDULING
 2742 Front Street
 Cuyahoga Falls, OH 44221
 Phone (330) 996-8881
 Fax (330) 996-8600
 Attention: Scott Bible/Supervisor Designee

Physician Please Complete

Patient Name: _____

Diagnosis(es): _____

Additional Comments: N/A

Physician Signature: _____ NPI # _____ Date: _____

<i>Sleep Study Requested</i>			<i>Significant Medical Conditions</i>	
<input type="checkbox"/> Sleep Study Consultation	<input type="checkbox"/> Sleep Study—PSG with MSLT	<input type="checkbox"/> Sleep Study—Daytime PAP/Bilevel with MSLT	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Sleep Study—PSG (Baseline)	<input type="checkbox"/> Sleep Study—PAP/Bilevel Titration with MSLT	<input type="checkbox"/> Sleep Study—PSG	<input type="checkbox"/> Diabetes	<input type="checkbox"/> COPD
<input type="checkbox"/> Sleep Study—PAP/Bilevel Titration	<input type="checkbox"/> Sleep Study—Daytime PSG (Baseline)			

Reading Physician (Select One)

Neurology & Neuroscience Associates (NNA)	NE Ohio Pulmonary Critical Care (NPCS)	Summa Physicians Inc. (SPI)	Independent Physician	No Preference
<input type="checkbox"/> Dr. L. Saltis <input type="checkbox"/> Dr. F. Roman	<input type="checkbox"/> Dr. H. Makkar <input type="checkbox"/> Dr. M. Passero	<input type="checkbox"/> Dr. B. Graef	<input type="checkbox"/> Dr. N. Lefkovitz*	<input type="checkbox"/> No Preference
<input type="checkbox"/> Dr. J. Rafecas <input type="checkbox"/> Dr. Z. Lewton	<input type="checkbox"/> Dr. M. Krauzua <input type="checkbox"/> Dr. S. Tewari		<small>* Does not perform studies at Summa Western Reserve Hospital</small>	
	<input type="checkbox"/> Dr. N. Botros <input type="checkbox"/> Dr. Kar-Ming Lo			

To comply with accreditation standards of the American Academy of Sleep Medicine, the below clinical history must be provided.

Check Applicable Symptoms

<input type="checkbox"/> Excessive Daytime Somnolence	<input type="checkbox"/> Cataplexy	<input type="checkbox"/> Numbness/Tingling in Legs	<input type="checkbox"/> Morning Headaches	Height _____
<input type="checkbox"/> Sleep Attacks	<input type="checkbox"/> Snoring	<input type="checkbox"/> Wake Feeling Unrefreshed	<input type="checkbox"/> Stops Breathing at Night	Weight _____
<input type="checkbox"/> Cramps in Legs	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Unusual Behaviors (Sleep walking/talking)	<input type="checkbox"/> Fatigue	BP _____

Medications: _____ Brief Clinical Description _____

Medication Allergies: _____

Upper Airway Exam: _____

Systems Exam: _____

Physician's Office Please Complete

Patient Demographic Information		Primary Insurance (Carrier Information)	
SSN	DOB	Insured's Name	Insured's DOB
Marital Status (circle) S M D W	Sex (circle) M F	Insured's Relationship	
Address		Employer Name	
		Insurance Company	
		Insurance Phone (# on Insurance card)	
City/State/Zip Code		Policy #	Group #
		Authorization # (if applicable)	
Secondary Insurance			
Home Phone	Cell Phone	Insured's Name	Insured's DOB
		Insured's Relationship	
Employer	Work Phone	Employer Name	
		Insurance Company	
Please Print Ordering Physician's Name		Insurance Phone (# on Insurance card)	
		Policy #	Group #
		Authorization # (if applicable)	

★ **DO NOT FORGET TO COMPLETE** Patient Demographic information submitted by Order form Email Fax (number listed at top of form)

This Section to be completed by Centralized Scheduling Only

Appointment Date _____ Appointment Time _____ Prep/Instructions Yes No Faxed Itinerary/Prep Instructions Yes No

Facility Summa St. Thomas Hospital Summa Western Reserve Hospital White Pond Sleep Medicine Center Green Sleep Medicine Center Medina Sleep Medicine Center

Comments _____ Scheduler _____ Date _____

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