SUNY DOWNSTATE Medical Center

SLEEP DISORDERS CENTER
3839 Flatlands Avenue, Brooklyn, NY 11234
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www.downstate.edu/sleep

ADULT SLEEP STUDY FORM

PATIENT INFORMATION

Patient's Name: ______________________________ Sex: ❒ M ❒ F D.O.B. ______/______/_______

Insurance Carrier: ______________________ Home Phone: ____________________ Cell Phone: ____________________

Do you snore?	❒ Yes ❒ No		Do you have heart problems?	❒ Yes ❒ No
Do you gasp or stop breathing during sleep?	❒ Yes ❒ No		High blood pressure?	❒ Yes ❒ No
Do you experience daytime sleepiness?	❒ Yes ❒ No		Diabetes?	❒ Yes ❒ No
Do you have morning headaches?	❒ Yes ❒ No		Lung problems?	❒ Yes ❒ No
			Are you overweight?	❒ Yes ❒ No

ATTENTION!!! THIS FORM MUST BE SIGNED BY THE REFERRING PHYSICIAN.

Referring physician (print): ______________________________ Office Phone: ______________________

Physician's Signature: ______________________ Date: _____ /_____ /_____ Office Fax: ______________________

RULE OUT OR CONFIRM THE FOLLOWING

(Please check all that apply)

❏ Sleep Apnea
❏ Narcolepsy/Hypersomnia
❏ Periodic Limb Movement Disorder

TYPE OF STUDY REQUESTED

❏ Consultation & Nocturnal Polysomnography (NPSG)
❏ Split Night Study
❏ CPAP/BiPAP (if indicated by the outcome of NPSG)
❏ ASV Titration Study
❏ MSLT
❏ MWT
❏ Mask Fitting / Desensitization ❏ PAP / NAP

SPECIAL NEEDS OF PATIENT

❏ Tracheostomy tube
❏ Home suctioning – trach / nasal / oral
❏ Home oxygen use __________LPM
❏ Wheelchair
❏ Morbid Obesity

Medical Diagnosis: ____

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