# *Faulkton Medical Center*

**Sleep Study Referral Order Form**

**Fax: (763) 201-5545 or (218) 844-6151**

Date________________ Diagnosis____________________________________________________

Patient Name___________________________ M or F DOB_________

SSN_________________

Address ___________________________ City_________________ State___ Zip code__________

Home Phone ___________________ Work Phone_________________ Cell Phone _____________

Primary Insurance___________________ ID# _______________________Group#______________

Secondary Ins______________________ ID# _______________________Group#______________

Email Address ____________________________________________________________________

Race__________________________ Ethnicity ________________________ Lang. _______________________

## Please Check Appropriate Boxes:

☐ Baseline Study (Baseline Sleep Study without CPAP Titration)

☐ Split Night Study (Baseline Sleep Study with CPAP Titration if AHI 15 or >)

☐ Titration Study (Requires CPAP Titration Only)

☐ MSLT or MWT (Check box If Indicated)

☐ Consultation with Sleep Specialist

☐ Consultation with CPAP Specialist only

☐ Sleep Aid if indicated ***Referring Doctor must order this to your pharmacy of choice***

***Marking this only lets us know patient will be bringing this medication with them***

PRN sedative, please indicate one of the following:

Ambien ☐5mg ☐10mg x 1 @ HS the night of the study

**Is the patient a danger to him/herself or to others due to excessive daytime somnolence (i.e. driving)?** **YES** **NO**

Physician Signature______________________ Physician Name (Please Print) __________________

Date _________ UPIN# _________ Phys. Phone# _______________ Physician Fax#________

**Diagnostic Sleep Services provided by**

*Whitney* **SLEEP DIAGNOSTICS AND CONSULTANTS**


119 Graystone Plaza Suite 102, Detroit Lakes, MN 56501

**P (218)844-6150 F (763)201-5545**