Appt. Date_______________

Straight Medi-Cal. ☐

Overnight Sleep Study PHYSICIAN ORDER SHEET

SLEEP CENTER

4650 W. Sunset Blvd MS#128, Los Angeles, CA 90027
Phone: (323) 361-2162 Fax #: (323) 361-1364

☐ 1:1 ☐ 2:1

Criteria for 1:1
- <5years
- Trach Capping
- New CPAP/BiPAP Titration
- Uncooperative Patients

(TO BE COMPLETED BY REFERRING PHYSICIAN)

PATIENT NAME: ____ **DOB:** __________ **MR#**______________

DIAGNOSIS: 1. ____________________ 2. ____________________ 3. ____________________

Medications: 1. __________________ 2. ___________________ 3. _______________ 4. _______________

Sleep Related Symptoms: ____ Ht: ___________ Wt: __________kg

Is patient physically disabled? NO____ YES_____ If *yes,* please explain:______________________________________

Is patient currently on nasal CPAP, BiPAP, or Ventilator? NO. _____ YES_____

(CPAP/ BiPAP) IPAP:__________ EPAP:__________ MODE:__________ RATE:__________

(Ventilator) Type ________ Mode ________ Rate ________ PIP ________ PEEP: ________ PS ________ I time ________

Is patient currently on supplemental O2? ____ NO _____YES ***MODE _____ LPM/FIO2:_______***

Is patient developmentally delayed? _____NO _____YES Is patient able to cooperate? ______NO ______YES

TEST REQUESTED (CHECK ONE): **Indication for Study:** ______________________________________

( ) Diagnostic Polysomnography (baseline sleep study) → NO TREATMENT/ OBSERVATION ONLY

Polysomnography with Therapy:

( ) Start study on room air, then place pt on O2 and titrate oxygen per CHLA protocol

( ) Start study with pt on oxygen (______l/min), and titrate oxygen per CHLA protocol

( ) Assess ventilation and oxygenation during sleep with open trach

***Polysomnography with Therapy Complex** (Medical Director approval required prior to scheduling)

( ) Assess ventilation and oxygenation during sleep with trach capped*

( ) Split Study: Baseline sleep study 2-3 hours, then add CPAP/BIPAP per CHLA protocol

( ) CPAP titrate per CHLA protocol ( ) BIPAP titrate per CHLA protocol ( ) Ventilator Check *

Range goals for Sp02____________ PetC02_______________

*REQUIRES **Sleep Lab Medical Director Approval** ________________________

*Special Instructions/Considerations:____

Referring Physician Name: ______________________________ Phone #:__________________Fax :______________

Address:____

Physician Signature:____________________________ Date:__________________

For Office Use Only

- ☐ Authorization, insurance card, progress note attached
- ☐ HMO—Auth. exp date:______________________

Med GRP/IPA:______________________________

Ins. Carrier:______________________________

- ☐ Letter sent
- ☐ Waiting list
- ☐ Incomplete Referral

☐ OUTPATIENT ☐ INPATIENT

FL______RM_____

Tech completing study:______________________________

Storage disk #:____________Reader station (d) file #:______

Reader station (d) file #:____________

Previous study date:________ ( ) copy attached ( ) not avail.

Staff comments:____