Atlantic
Sleep and Rehab Centers

APPOINTMENT LINE: (910) 681-1050 REFERRAL E-FAX: (888) 977-2752

7211 Ogden Busniess Lane
Wilmington, NC 28411

Patient: _____ DOB: _____

Address: _____

Phone/Home: _____ Cell: _____ Other:_____

(Please include office notes and insurance information)

Primary Insurance: _____ Secondary Insurance: _____

SELECT TYPE OF STUDY:

- ☐ Diagnostic Polysmnography (Sleep Study)
- ☐ CPAP / BILEVEL Titration Polysmnography
  (only if obstructive sleep apnea previously documented by sleep study)
- ☐ Split Diagnostic (if criteria for obstructive sleep apnea is met)
- ☐ MSLT / Multiple Sleep Latency Test (following Diagnostic Polysomnography)
- ☐ MWT / Multiple Wake Test

DIAGNOSIS: _____

_____

SYMPTOMS / SIGNS:

- ☐ Hypersomnolence/excessive sleepiness
- ☐ Fatigue
- ☐ Insomnia
- ☐ Snoring
- ☐ Witnessed Apnea
- ☐ CHF
- ☐ MI
- ☐ Stroke
- ☐ HTN
- ☐ COPD
- ☐ Obesity
- ☐ Irritability / behavioral disorder
- ☐ Cognitive impairment
- ☐ Enuresis / bed wetting
- ☐ Morning Headache
- ☐ Patient currently on OXYGEN ☐ NO ☐ YES (LPM: _____)

REFERRING PHYSICIANS:

Please indicate if you want the interpreting physician to notify the patient of their sleep study results.

☐ YES ☐ NO FOLLOW UP AS NEEDED? ☐ YES ☐ NO

_____ _____

Physician Signature NPI NUMBER Date

_____

Printed Physician Name

REV 06-2010