**INSTRUCTIONS TO PHYSICIAN:**
Please complete this form, and return by fax to (202) 555-1212

The Centers’ Sleep Care Specialist will contact the patient to schedule tests that you have ordered.

**TYPE OF VISIT REQUESTED:**
- [ ] I request that the visit / procedure be determined by a board-certified physician at the Sleep Disorder Center.
- [ ] Initial Consultation
- [ ] Follow-Up Visit
- [ ] Nocturnal Polysomnograph
- [ ] Nasal CPAP Titration
- [ ] Multiple Sleep Latency Test
- [ ] Cardiac Monitoring (Holter)
- [ ] Maintenance of Wakefulness Test (MWT)
- [ ] Other ___________________________________________________________________________________

**PATIENT REFERRED TO EVALUATE THE FOLLOWING**
- [ ] Sleep Apnea
- [ ] Restless Legs
- [ ] Narcolepsy
- [ ] Periodic Limb Movement Disorder
- [ ] Insomnia
- [ ] Daytime Sleepiness
- [ ] Other ___________________________________________________________________________________

**PATIENT HISTORY**
- Snoring: [ ] YES [ ] NO
- Grasping or choking during sleep: [ ] YES [ ] NO
- Apneic events witnessed by partner: [ ] YES [ ] NO
- Discomfort or restlessness of lower limbs before / during sleep: [ ] YES [ ] NO
- Twitching, jerking, or kicking of lower limbs before or during the sleep period: [ ] YES [ ] NO
- Daytime sleepiness or fatigue: [ ] YES [ ] NO

**MEDICAL CONDITIONS:**

**CURRENT MEDICATIONS:**

**ASSISTANCE REQUIRED FOR AMBULATION, TOILETING, OR OTHER ACTIVITIES?**
- [ ] NO [ ] YES: PLEASE EXPLAIN >>

**REFERRING PHYSICIAN**

**PART OF THE MEDICAL RECORD**