## *PHYSICIAN DIRECT SLEEP STUDY ORDERS*
### *For Use by WUSM: Neurology, Otolaryngology and Pulmonary physicians*

**Patient Name:** ____________________________________________________________**DOB:** ______________________
**Primary Insurance:** __________________________________________ **Member #** _______________________________
**Secondary Insurance:** _________________________________________ **Member #** ______________________________
**Precertification Required? No**______ **Yes** _________ **Auth #** __________________________________________________
**Case Manager Name/ #** _________________________________________________________________________________

**Please indicate below your request.**
**Fax H/P along with demographics and a copy of the Patient's insurance card to 314.747.3813.**

***REASON FOR THE STUDY***

*Circle:* *SNORING* *WITNESSED APNEAS* *OSA* *EDS* *RESTLESS SLEEP* *COMPLEX SLEEP APNEA* *NARCOLEPSY* *RLS*

*OTHER:* ________________________________________________________

**ANPSG** **PCO2 MONITORING**

**SPLIT STUDY** **ETCO2 MONITORING**

**MSLT DECISION (screen after SLT# 2)** **MWT**

**FULL MONTAGE EEG** **ARM LEADS**

**CPAP TITRATION:** _____________________________

**Auto CPAP:** Min ______; Max_______; EPR/FLEX mode ______

**PHILIPS RESPIRONICS BIPAP**
Mode ___________; IPAP ________; EPAP ________; Rate ______; Flex ______; Rise ______; Time insp _______

**ResMed VPAP**
Mode _______; IPAP _____; EPAP _____; Rate ______; Rise ____; Ti max ____; Ti min ____ Trigger ____; Cycle _____

**PHILIPS RESPIRONICS BIPAP AUTO**
IPAP max ________; EPAP min ________; Max PS ________; Rise _______; Flex ________

**RESMED VPAP AUTO 25**
Max IPAP ______; Min EPAP ______; PS ____; Ti max ____; Ti min _____; Trigger _____; Cycle_____; Exhale _______

**PHILIPS RESPIRONICS AUTO SV**
Max Pressure _________; EPAP min _________; EPAP max _______; PS min_____; PS max _______; Rate _____;
Rise ______; Biflex _______

**RESMED VPAP ADAPT SV**
EEP __________; max PS ________; min PS _________

**PHILIPS RESPIRONICS AVAPS**
IPAP max ______; IPAP min _______; EPAP _______; Vol ________; Time Insp _______; Rate _______; Rise ________

**SUPPLEMENTAL O2 ORDER:** ______________________________________________________________________________

**MEDICATION ORDER:** __________________________________________________________________________________

**ADDITIONAL ORDERS**: ________________________________________________________________________________
_____________________________________________________________________________________________

**PHYSICIAN (print)** ________________________________**SIGNATURE**____________________________________
**DATE** ______________________________**DEPARTMENT/SECTION** ____________________________________
**PHONE #**____________________**PAGER#** ____________________**FAX RESULTS TO #** ________________________

**Reviewed by Sleep Physician** ____________________________________________**Date** ________________________
**Comments**
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________