UNIVERSITY of MARYLAND SHORE REGIONAL HEALTH
SLEEP DISORDERS CENTER

UM SHORE MEDICAL CENTER AT EASTON
219 S. Washington Street
Easton, MD 21601

UM SHORE MEDICAL PAVILION
125 Shoreway Drive
Queenstown, MD 21658

UM SHORE MEDICAL CENTER AT DORCHESTER
300 Byrn Street
Cambridge, MD 21613

(410) 822-1000 ext. 5338 | Fax: (410) 763-7051
www.umshoreregional.org/programs/sleep

SLEEP STUDY REQUEST FORM

*Please **COMPLETE** this form (**to be completed by referring physician**) and fax **demographic information with **MOST RECENT OFFICE NOTES** to (410) 763-7051*

PATIENT INFORMATION:

Name: _____Birth Date: _____ Best Contact #: _____

Primary Care Physician: _____Gender: M / F Height: _____Weight: _____Neck Size:____

Select the following that apply: ❑DOT Certification ❑Pre-Op Testing Employment Hours: ❑Day ❑Overnight

STUDY REQUESTED:

- ❑ Standard Diagnostic PSG Study *(Conversion to Split-night per protocol for AHI>40 is standard; if PSG is denied by insurance, Home Sleep Test will be substituted, if applicable)*
- ❑ Pediatric (< 8 *Must have scheduled pre-study visit to sleep lab)*
- ❑ Other:_____

PLEASE READ REGARDING FOLLOW UP:

We **DO NOT** schedule follow-up appointments with sleep specialists for patients to review their results.
All testing results will be faxed to ordering physician.
After results are received, follow-up appointments can be scheduled at the discretion of the ordering physician.

UMCMG – Neurology	UMCMG – Pulmonary Care
Sleep Specialist - 410-770-5250	Sleep Specialist - 410-822-0110

RELEVANT MEDICAL HISTORY (Must fax most recent history and physical for approval):

Existing Conditions: ❑Seizures D.O ❑Anxiety ❑Smoking ❑GERD ❑CHF
❑Hypertension ❑AFIB/ Arrhythmias ❑Depression ❑COPD ❑Asthma ❑Diabetes
❑Obesity ❑Coronary artery disease ❑*Other*: _____

Primary Symptoms: ❑Large Neck ❑Sleep Paralysis ❑Cataplexy
❑Witnessed Apneas ❑Frequent snoring ❑Excessive daytime sleepiness ❑Nocturia
❑Choking ❑ Irregular Breathing ❑Headaches ❑Nocturnal Dyspnea
❑Difficulty falling asleep ❑Hypnogogic Hallucinations ❑Automatic Behavior ❑Frequent leg movements
❑Repetitive Violent or Injurious Behavior

Special Needs: ❑Nocturnal Oxygen ____LPM ❑Urinary / Stool Incontinence ❑Medications
❑Interpreter ❑*Other*: _____

SUSPECTED DISORDERS (Check all that apply)

❑Obstructive Sleep Apnea ❑Central Apnea ❑ Chronic Respiratory Failure
❑Periodic Limb Movements ❑Narcolepsy ❑ Parasomnias Behavior (e.g. sleepwalking, RBD, bruxism etc)

REFERRING PHYSICIAN INFORMATION (REQUIRED)**:**

Phone: _____ Fax: _____

Ordering Physician/Practitioner (PRINT): _____

Physician Signature: _____ Date: _____

Approval by RSDC Medical Director: _____ *Date:* _____*Time:*_____