



# REQUISITION FORM

Phone (608) 232-3333

fax (608) 231-9011

toll free (877)53-SLEEP

wisconsinsleep.org

## Patient Information (Please Print)

Name \_\_\_\_\_ Home phone \_\_\_\_\_ DOB \_\_\_\_\_  
 Street Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
 Work/cell phone \_\_\_\_\_ M/F \_\_\_\_\_ Email \_\_\_\_\_  
 Insurance \_\_\_\_\_ ID # \_\_\_\_\_ Subscriber # \_\_\_\_\_

## Services Requested: (Check one box only)

<b>Sleep Testing Only</b> <input type="checkbox"/> Polysomnography	<b>NO FOLLOW-UP SERVICES</b> ➤ Includes sleep test, initiate CPAP titration during test if indicated <input type="checkbox"/> Check here if you do not want CPAP initiated during test
<b>Sleep Testing &amp; Consultation</b> <input type="checkbox"/> Polysomnography with consultation if indicated based on test results	➤ Overnight sleep test. Includes sleep test, initiate CPAP titration during test if indicated, evaluate patient and give opinion/advice on diagnosis and/or treatment. <input type="checkbox"/> Check here if you do not want CPAP initiated during test
<b>Clinic Services</b> <input type="checkbox"/> Consultation only <input type="checkbox"/> Transfer of care until condition stabilized	➤ Clinic consult to evaluate patient and give opinion/advice. ➤ Appointment in clinic to evaluate and treat the patient as deemed appropriate

## Medical History (Non UW Health Providers: Please forward most recent history and physical and clinic note)

### Suspected Disorders

- Sleep Apnea
- Narcolepsy
- Insomnia
- Restless Legs/Periodic Limb Movements
- Night-time seizures
- Sleep walking/night terrors
- Bed wetting
- Abnormal nighttime behaviors
- Excessive Sleepiness
- Other

### Primary Symptoms

- Loud snoring
- Obese/large neck
- Difficulty falling asleep
- Difficulty staying asleep
- Daytime sleepiness
- Witnessed apneas
- Restless Legs
- Morning headaches
- Sleep Walking
- Nightmares
- Night terrors
- Seizures

### Special Needs

- Oxygen at night (\_\_\_ liter/min)
- Interpreter (language \_\_\_\_\_)
- Wheelchair
  - Regular
  - Extra large
- Other

## Referring Physician:

Name \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 Email \_\_\_\_\_  
 Physician's signature \_\_\_\_\_

## Primary Care Physician (Same as referring?) (Y/N)

Name \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 Date \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

MR Number or Date of Birth: \_\_\_\_\_

## Patient Medical History Questionnaire

For Use When Considering  
Sleep Disordered Breathing

**PLEASE CHECK (✓) ON THE APPROPRIATE LINE FOR EACH QUESTION OR FILL IN ANSWER.**

**Category #1**

1. Do you snore?  
Yes \_\_\_\_\_  
No \_\_\_\_\_  
Do not know \_\_\_\_\_
2. Snoring loudness?  
Loud as breathing \_\_\_\_\_  
Loud as talking \_\_\_\_\_  
Louder than talking \_\_\_\_\_  
Very loud \_\_\_\_\_
3. Snoring frequency?  
Almost every day \_\_\_\_\_  
3-4 times/week \_\_\_\_\_  
1-2 times/week \_\_\_\_\_  
1-2 times/month \_\_\_\_\_  
Never or almost never \_\_\_\_\_
4. Does your snoring bother other people?  
Yes \_\_\_\_\_  
No \_\_\_\_\_
5. How often have your breathing pauses been noticed?  
3-4 times/week \_\_\_\_\_  
1-2 times/week \_\_\_\_\_  
1-2 times/month \_\_\_\_\_  
Never or almost never \_\_\_\_\_

**Category #2**

6. Are you tired after sleeping?  
Almost every day \_\_\_\_\_  
3-4 times/week \_\_\_\_\_  
1-2 times/week \_\_\_\_\_  
1-2 times/month \_\_\_\_\_  
Never or almost never \_\_\_\_\_
7. Are you tired during wake time?  
Almost every day \_\_\_\_\_  
3-4 times/week \_\_\_\_\_  
1-2 times/week \_\_\_\_\_  
1-2 times/month \_\_\_\_\_
8. Have you ever fallen asleep while driving?  
Almost every day \_\_\_\_\_  
3-4 times/week \_\_\_\_\_  
1-2 times/week \_\_\_\_\_  
1-2 times/month \_\_\_\_\_

**Category #3**

9. Do you have high blood pressure?  
Yes \_\_\_\_\_  
No \_\_\_\_\_
10. What is your height?  
\_\_\_\_\_ Feet \_\_\_\_\_ Inches
11. What is your weight in pounds?  
\_\_\_\_\_
12. What is your age? \_\_\_\_\_
13. Are you male or female?  
Male \_\_\_\_\_ Female \_\_\_\_\_
14. For males, what is your shirt neck size? \_\_\_\_\_

**EPWORTH SLEEPINESS SCALE**

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate answer in each situation

	0	1	2	3
	Would never doze	Slight chance of dozing	Moderate chance of dozing	High chance of dozing
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (e.g. a theater or a meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, stopped in traffic for a few minutes	0	1	2	3

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

MR Number or Date of Birth: \_\_\_\_\_

## Patient Medical History Questionnaire

For Use When Considering Sleep Disordered Breathing

**PAST MEDICAL HISTORY (THIS MEANS ANY MEDICAL PROBLEMS):** Have you ever been told by a doctor or other health professional that you had or now have any of the following? Please check all that apply. If you are unsure of the answer, please choose "NO".

YES	NO	YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>Sleep apnea If yes, which treatments for sleep apnea have you had? (check all that apply):  <input type="checkbox"/>None <input type="checkbox"/>CPAP/BiPAP  <input type="checkbox"/>Dental device <input type="checkbox"/>Surgery  <input type="checkbox"/>Weight lost <input type="checkbox"/>Other <input type="checkbox"/>Don't know</p>		<p>A sleep disorder other than sleep apnea If yes, check all that apply:  <input type="checkbox"/>Insomnia <input type="checkbox"/>Restless legs  <input type="checkbox"/>Narcolepsy <input type="checkbox"/>Don't know  <input type="checkbox"/>Other. Please describe: _____</p>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nasal allergies, including hay fever		Sinus problems (not allergies)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma		Nasal polyps (growth inside your nose)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema		Emphysema	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic bronchitis		Vocal cord problems: If yes, please describe: _____	
<input type="checkbox"/>	<input type="checkbox"/>	_____	
Gastroesophageal reflux disease		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Stomach ulcer	
High blood pressure		<input type="checkbox"/>	<input type="checkbox"/>
Angina, also called angina pectoris		Coronary heart disease	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack (myocardial infarction)		Heart failure	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary hypertension (high lung pressure)		Heart irregularity/heart rhythm problem	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurologic disease (e.g. Parkinson's, multiple sclerosis)		Peripheral vascular disease	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia (a lot of muscle aches & pains)		Epilepsy or seizures	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis		Stroke	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes		Dementia	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems		Chronic back pain	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you on kidney dialysis?		High cholesterol	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye problems (e.g. glaucoma)		Kidney disease	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar disorder (panic, obsessive-compulsive, PTSD, generalized anxiety)		Blood problems (anemia or polycythemia)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other psychiatric diagnosis? If yes, please describe _____		Menopause	
_____		<input type="checkbox"/>	<input type="checkbox"/>
		Other medical condition not listed above? If yes, please describe _____	
		_____	

Symptoms of Restless Legs Syndrome: Please <i>circle</i> the most appropriate answer for each of the following questions.			
A.	Do you have unpleasant sensations (creepy-crawling, aching, pulling) in your legs combined with an urge to need to move your legs?	YES	NO
B.	Do these sensations occur mainly or only at rest and do they improve with movement?	YES	NO
C.	Are these sensations worse in the evening or night than in the morning?	YES	NO