Cleveland Clinic

Dear Referring Provider,

Thank you for choosing Cleveland Clinic Sleep Disorder Center as a partner in the care of your patients with sleep disorders.

** Please fax **all of the** following items to **(216) 445-6205** to allow us to process your order:

- ☐ Completed/Signed Sleep Requisition – located on the back of this form.
- ☐ Recent office clinic note
- ☐ Previous sleep study (if available) if not performed at a Cleveland Clinic facility
- ☐ Medication list (either separate or included on the recent office notes)
- ☐ Demographics
- ☐ Insurance information

Please note that we need **all of the items** listed above provided to us for an order to be classified as "complete".

Incomplete orders will be returned to the provider with identified missing items and placed on hold until requested materials are received. Please refer to the list above. (**)

Complete orders will be protocolled to determine appropriateness of the test ordered as per laboratory guidelines and various insurance inclusion/exclusion criteria.

We will notify your office once an order is classified as ***complete*** and in the process of being scheduled. We will attempt to call your patients up to 3 times within one week following our receipt of a completed order. Patients can also call our appointment center line directly at **(216) 636-5860** within same timeframe.

Your patients' test results will be faxed to your office within a week following the completion of the study.

We look forward to collaborating on the care of your patients. If you have any questions, or need to speak with a member of our staff, please do not hesitate to contact us at **(216) 444-2165**.

Complete **left side of form** for In lab Polysomnogram or Home Sleep Test / Complete **right side of form** for all other sleep related tests.

POLYSOMNOGRAPHY (PSG) is the gold-standard test for evaluation of several sleep disorders including sleep-related breathing disorders, and suspected obstructive sleep apnea (OSA) with co-morbid sleep disorders (circadian rhythm disorders, narcolepsy, parasomnias, periodic limb movements, insomnia) or medical disorders (heart failure, moderate-to-severe cardiac and pulmonary diseases, neuromuscular disease, morbid obesity).

HOME SLEEP TESTING (HST) is a confirmatory test for patients 18-65 years of age with ***HIGH*** pre-test OSA probability. *HIGH* pre-test probability requires at least 3 of the following: *Snoring, Tiredness/daytime sleepiness /fatigue, Observed apnea, high blood Pressure, BMI >35, Age >50; Neck girth >40cm, male Gender.*

HST is **NOT recommended** for patients with the aforementioned co-morbidities, for evaluation of sleep disorders other than OSA, or for patients < 18 years of age.

PAP TITRATION STUDY applies various types of therapy to the upper airway for treatment of sleep apnea. This study should be ordered after the diagnosis of sleep apnea is confirmed by PSG or HST.

PSG with 18 channels EEG incorporates PSG and video EEG for the evaluation of unexplained behaviors and movements during sleep in which seizures are strongly suspected.

DAYTIME TESTING includes the Multiple Sleep Latency Test (MSLT) and Maintenance of Wakefulness Test (MWT). MSLT is indicated as part of the evaluation of narcolepsy and idiopathic hypersomnia. MWT is a variation of MSLT that may be used in the assessment of individuals in whom the inability to remain awake constitutes a safety issue, or in patients with narcolepsy or idiopathic hypersomnia to assess response to treatment.

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Patient Name: **DOB:**__ __/__ __/__ __ __ __ **Date:** __ __/__ __/20__ __

Ordering Provider: **Phone:** **Fax:**

POLYSOMNOGRAPHY (PSG) and HOME SLEEP TESTING (HST)
Test requested (mark one)
☐ PSG (Gold standard)
☐ HST

Completion of all sections is required

1. **Suspected sleep disorders (mark all that apply)**
   - ☐ Obstructive sleep apnea (snoring, witnessed apnea, daytime sleepiness, fatigue)
   - ☐ Central sleep apnea (restless sleep, night awakenings, daytime sleepiness, fatigue)
   - ☐ Nocturnal oxygen desaturations
   - ☐ Narcolepsy/Hypersomnia (daytime sleepiness, cataplexy, sleep paralysis
   - ☐ Abnormal/injurious sleep activity (seizures, parasomnias, limb movement)
   - ☐ Sleep enuresis (bed-wetting)
   - ☐ Sleep bruxism (teeth grinding)
   - ☐ Insomnia (diagnosis alone insufficient to perform sleep test)
   - ☐ Restless legs syndrome (diagnosis alone insufficient to perform sleep test)
2. **PSG recommended in patients with any of the following (mark all that apply)**
   - ☐ Cognitive impairment, disability, other special needs
   - ☐ Heart failure or other moderate-to-severe cardiac disease
   - ☐ Significant, persistent cardiac arrhythmias
   - ☐ Neurologic diseases including neuromuscular disease or stroke
   - ☐ Moderate-to-severe pulmonary disease
   - ☐ Morbid obesity (BMI $\geq$ 40 kg/m^2)
   - ☐ Shift worker
   - ☐ None
3. **If OSA suspected, mark all that apply (3 or more required for HST eligibility)**
   - ☐ Snoring that is loud and disruptive
   - ☐ Tiredness, fatigue, or sleepiness during the daytime
   - ☐ Observed apnea (cessation of breathing) during sleep
   - ☐ High blood pressure
   - ☐ BMI > 35 kg/m^2
   - ☐ Age > 50 years
   - ☐ Neck girth > 40 cm (15.75)
   - ☐ Male gender
   - ☐ Not Applicable
4. **For a repeat PSG, mark at least one of the following**
   - ☐ New, continuing or worsening symptoms or high OSA probability despite inconclusive HST (detail in Comments)
   - ☐ Change in BMI > 5 kg/m^2
   - ☐ Recent upper airway surgery
   - ☐ Use of an oral appliance or end expiratory pressure relief
   - ☐ High probability OSA, First HST negative
   - ☐ Previous diagnosis of OSA previous results unavailable
   - ☐ Not applicable

☐ **PAP TITRATION STUDY**

1. **Type of sleep-related breathing disorder (mark all that apply)**
   - ☐ Obstructive sleep apnea
   - ☐ Central sleep apnea
   - ☐ Sleep-related hypoventilation
2. **Modality (additional modes will be initiated if indicated)**
   - ☐ Continuous positive airway pressure (CPAP)
   - ☐ Bi-level positive airway pressure (Bi-level PAP)
   - ☐ Other (detail in Comments)
   - ☐ Oral appliance therapy
3. **If diagnostic study was not performed at Cleveland Clinic, provide the following information:**
   Date of study: __ __/__ __/20__ __
   Type of study: ☐ In-lab PSG ☐ HST
   Apnea-hypopnea or Respiratory disturbance index: __ __ __. __
4. **Current PAP mode and pressure**
   - ☐ CPAP ___ ___ cmH_2O
   - ☐ Bilevel PAP ___ ___ cmH_2O
   - ☐ Other _____
5. **For a repeat Titration, mark at least one of the following**
   - ☐ New, continuing or worsening symptoms (detail in comments)
   - ☐ Pressure intolerance or leak
   - ☐ Change in BMI > 5 kg/m^2
   - ☐ Recent upper airway surgery

☐ **PSG with 18 channels EEG**

DAYTIME SLEEP TESTS:
Test requested (mark one)
☐ MSLT
☐ Urine Toxicology Screen (typically this can be ordered for the morning of the MSLT)
Check box if you would like this test done with the MSLT.
☐ MWT

Symptoms (mark all that apply)
- ☐ Daytime sleepiness
- ☐ Cataplexy
- ☐ Sleep paralysis
- ☐ Sleep related hallucinations
- ☐ Other (detail in comments)

☐ **Check if a Sleep Medicine consultation is requested** (consultation and PAP set up are not automatically scheduled with testing)
Comments/Special Requests: _____

ORDERING PROVIDER SIGNATURE_____

Please call (216) 444-2165 with questions. Please call (216) 636-5860 to schedule, cancel or change an appointment.