Wentworth−Douglass Hospital, Sleep Disorders Center
789 Central Ave., Dover, NH 03820
Phone: 603−740−6598 − Fax: 603−740−3310

ORDER FORM FOR THE EVALUATION & TREATMENT OF OBSTRUCTIVE SLEEP APNEA

Patient Name: _____ DOB: _____

Ordering Physician: _____ Diagnosis: _____

Symptoms associated obstructive sleep apnea:

LEVEL I − Low Risk patients with high clinical index for OSA (see below)

Symptoms:

- ❑ History of snoring or witnessed apnea
- ❑ Restless sleep
- ❑ Excessive daytime sleepiness
- ❑ Hypertension

Evaluation features:

- ❑ Increased neck circumference (Male >17 in, Female >16 in)
- ❑ Body mass index (BMI) ≥ 30kg/m2
- ❑ Modified Mallampati Score of 3 or 4
- ❑ Intra−oral or nasal abnormalities
- ❑ Retrognathia.

LEVEL II − Patients with co−morbidities listed & Symptom and Evaluation Features for LEVEL I. Referral to Sleep Specialist is recommended prior to performing a Sleep Study.

Associated co−morbidities:

- ❑ Coronary Artery Disease
- ❑ Atrial Fibrillation
- ❑ Type 2 Diabetes/Metabolic Syndrome
- ❑ Cerebrovascular disease
- ❑ Nocturnal Arrhythmias
- ❑ Congestive Heart Failure
- ❑ Treatment Refractory Hypertension
- ❑ Pulmonary Hypertension
- ❑ High risk driving populations
- ❑ Evaluation for bariatric surgery

DIAGNOSTIC TEST ORDERS:

- ❑ PSG−Diagnostic (O2 Protocol). Await results to determine treatment.
- ❑ PSG−Diagnostic (O2 Protocol). If ABN Refer to Specialist or Sleep Specialist. **Refer To:** _____
- ❑ PSG−Home Sleep Test. Await results to determine treatment.
- ❑ PSG−Home Sleep Test. If ABN Refer to Specialist or Sleep Specialist. **Refer To:** _____

TREATMENT TEST ORDERS:

- ❑ PSG−CPAP Workshop Sleep Lab. Refer to Specialist or Sleep Specialist**. (To initiate Home Auto CPAP when mandated by insurance carrier.) Refer To:** _____
- ❑ PSG−CPAP titration (O2 Protocol). Refer to Specialist or Sleep Specialist. **Refer To:** _____
- ❑ PSG−Split Night (O2 Protocol). Refer to Specialist or Sleep Specialist. **Refer To:** _____
- ❑ PSG−Sleep Lab Follow−up. (To assist a patient currently on CPAP therapy)

Primary Care Provider Signature	**Primary Care Provider Name (print)**	**Date / Time**

Please Fax Completed Form to Sleep Lab at 603.740.3310 and Scheduling at 603.740.2398