Johns Hopkins Sleep Center
Bayview Medical Center and
The Johns Hopkins Hospital
Phone: 410-550-0571 || 443-287-3313
Fax: 410-367-2710

JOHNS HOPKINS MEDICINE

Patient Name: _____ **Patient Date of Birth**: _____

Patient contact numbers: _____ **(mobile)** _____**(home)** _____**(work)**

Requesting Physician: _____ **Physician Specialty**: _____

Address:_____**City:** _____ **State/Zip:** _____

Phone: _____ **Fax**: _____

Sleep Clinic Evaluation – Check ONE BELOW:

☐ Initial Sleep Clinic Evaluation
No other documentation is needed

OR

☐ Sleep Clinic evaluation **after** sleep study
Referring clinic visit note required

PLEASE INDICATE REASON FOR REFERRAL (e.g. snoring, witnessed apneas, sleepiness, insomnia, acting out dreams, restless legs syndrome, etc): _____

_____

Sleep Study – Please check one of the following (Please include referring provider H&P)

The H&P must include signs and symptoms of a sleep disorder or a sleep clinic consultation may be needed

☐ Diagnostic Polysomnography*†
(on room air unless specified)

☐ Home sleep apnea study

☐ CPAP titration

☐ Other, please specify:

_____

☐ BPAP titration

Special Needs or Instructions: _____

_____

*I would like a CPAP titration study if this baseline study is consistent with sleep apnea Yes No

† If insurance authorization for an in-lab diagnostic polysomnography study is denied, I would like a home sleep apnea study to be performed Yes No

REMINDERS:

- Please let your patient know that you are requesting a sleep disorder evaluation or a sleep study.
- **Medicare patients**: A face-to-face physician evaluation of patient, including history and physical exam, must be performed prior to polysomnography (sleep study). (As a Medicare requirement, patient's provider MUST provide us a copy of patient's medical record documenting evaluation of patient's need for a sleep study.)
- Prescription of PAP equipment, when indicated, is the responsibility of the referring provider. The Johns Hopkins Sleep Center will prescribe PAP equipment only after a clinic consultation.

I AUTHORIZE THE JOHNS HOPKINS SLEEP CENTER TO PERFORM A SLEEP STUDY ON THE ABOVE PATIENT ACCORDING TO THEIR PROTOCOLS, INCLUDING URGENT INITIATION OF PAP AND/OR OXYGEN.

Physician Name: _____ **Signature:** _____ **Date/Time:** _____