Accredited by American Academy of Sleep Medicine
Director, Mark Eric Dyken, MD

University of Iowa College of Medicine

Department of Neurology
Sleep Disorders Center
200 Hawkins Drive
Iowa City, Iowa 52242-1009
319-356-3813 Tele
319-356-4505 ***Fax***

Sleep Lab Requisition Form

Phone: 319-356-3813
FAX TO: 319-356-8383

For IowaCare Patients:

Phone: 319-356-1000
FAX TO: 319-384-9989

Patient Name: _____ Age: _____ DOB: _____

Street Address: _____ City _____ State _____ Zip: _____

Home Phone: _____ Work/Cell Phone:_____

Does the patient have an HMO/Managed care plan? Yes ____ No ____
If yes, has authorization been requested? Yes ____ No ____

****** PLEASE ATTACH COPY OF PATIENT'S MOST RECENT H&P (relating to this request). ******

Suspected Diagnosis (check appropriate boxes):
- ☐ Obstructive Sleep Apnea
- ☐ Central Sleep Apnea
- ☐ Other (specify)_____

Sleep History/Symptoms (check appropriate boxes):

☐ Sleepiness	☐ Morning headache	☐ GERD
☐ Snoring	☐ Insomnia	☐ s/p surgery for OSA
☐ Witnessed apneas	☐ Nocturia	☐ s/p oral device for OSA

Medical History (check appropriate boxes):

☐ Hypertension	☐ CHF	☐ Diabetes	☐ Mood Disorder	☐ Upper airway surgery (T&A/UP3)
☐ Pulmonary Hypertension	☐ CAD	☐ GERD	☐ Thyroid disease	
☐ COPD	☐ Stroke	☐ Fibromyalgia	☐ Latex allergy	

☐ Arrhythmia (describe)_____ Specify any other significant medical history _____

Height(cm)_____ **Weight**(kg) _____ **BMI**(kg/m²) _____ **Neck Circumference** (Cm)_____

Current O2 Therapy: None _____ Daytime only_____ Nocturnal only_____ Continuous _____ Lt./min._____
(Patient's that currently use continuous or nocturnal O2 will be studied on their prescribed O2 unless otherwise indicated)

Special Needs:
- ☐ Assistance ambulating_____ ☐ Wheelchair_____
- ☐ Interpreter, language_____ ☐ Other_____

Referring Physician Name *(printed)*: _____
NPI#_____
Specialty: ☐**Family Practice** ☐**Internal Medicine** ☐**Neurology** ☐**Pulmonary** ☐**Cardiology** ☐**ENT** ☐**Other (please specify)** _____
Clinic Name: _____**Address:**_____
City: _____ **State:** _____ **Zip:** _____
Contact Person: _____ **Phone:** _____ **Fax:** _____

Physician Signature *(required)*: _____