

Please choose the interpreting physician for your patient's study:

- No Preference
 Terese Hammond, M.D.
 Meena Mehta, M.D.
 Gary Stanton, M.D.

Patient Name _____ D.O.B. ____/____/____ Height _____ Wt _____ lbs.

Parent's Name and Phone Numbers: _____ H (____) _____ C _____

Usual Weekday Bedtime _____ AM/PM Weekend Bedtime _____ AM/PM

STUDY REQUESTED (Please Check Appropriate Boxes):

- | | |
|-------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Screening Sleep Study | All night diagnostic sleep study (PSG) to evaluate for all sleep disorders |
| <input type="checkbox"/> Standard Sleep Study (Split) | PSG will include CPAP initiation and titration if appropriate clinical criteria are met for obstructive sleep apnea (OSA). If criteria are met too late for treatment, patient will be scheduled for a subsequent CPAP titration night |
| <input type="checkbox"/> All Night PAP Titration | Sleep Apnea Syndrome must already be PSG-documented. Date of previous PSG: ____/____/____
Positive airway pressure (PAP) will be titrated to optimal pressure level |
| <input type="checkbox"/> Narcolepsy Study | All night diagnostic sleep study (PSG) with next day MSLT (Multiple Sleep Latency Test) |
| <input type="checkbox"/> Sleep Phase Study | All night diagnostic sleep study (PSG) testing for advanced/delayed sleep phase syndrome |
| <input type="checkbox"/> Other: | _____ |

CPAP EXPRESSCareSM I authorize Emerson Hospital Sleep Disorders Program to coordinate home CPAP, if clinically warranted, via its preferred DME vendor. Patient will use an auto titrating CPAP, incorporating a heated humidifier, delivering pressure from 6 cm H₂O to 3 cm H₂O above "optimal" pressure.

REASON FOR STUDY (Please Check Appropriate Boxes):

- | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Sleep Apnea/Upper Airway Resistance Syndrome
<input type="checkbox"/> Periodic Limb Movement Disorder/Restless Legs Syndrome | <input type="checkbox"/> Narcolepsy with or without Cataplexy
<input type="checkbox"/> Sleep-Associated Seizures
<input type="checkbox"/> Other: _____ |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|

MEDICAL/SLEEP HISTORY / SYMPTOMS (Please Check Appropriate Boxes):

- | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Snoring
<input type="checkbox"/> Witnessed Apneas
<input type="checkbox"/> Choking Noises
<input type="checkbox"/> Increased Work of Breathing
<input type="checkbox"/> Paradoxical Breathing
<input type="checkbox"/> Restless Sleep
<input type="checkbox"/> Frequent Awakenings
<input type="checkbox"/> Excessive Sleepiness
<input type="checkbox"/> Insomnia
<input type="checkbox"/> Nightmares
<input type="checkbox"/> Night Terrors
<input type="checkbox"/> Sleep Walking | <input type="checkbox"/> Leg Movements, Jerks, Cramps
<input type="checkbox"/> Bed Wetting
<input type="checkbox"/> Hyperextended Neck
<input type="checkbox"/> Dry Mouth
<input type="checkbox"/> Bruxism (teeth grinding)
<input type="checkbox"/> Morning Headaches
<input type="checkbox"/> Hyperactivity
<input type="checkbox"/> ADD or ADHD
<input type="checkbox"/> Aggressive Behavior
<input type="checkbox"/> Poor School Performance
<input type="checkbox"/> Seizures
<input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression/Bipolar
<input type="checkbox"/> Depression
<input type="checkbox"/> Overweight
<input type="checkbox"/> Hypertension
<input type="checkbox"/> Sinusitis / Rhinitis
<input type="checkbox"/> Asthma
<input type="checkbox"/> Allergies
<input type="checkbox"/> Ear Infections
<input type="checkbox"/> Enlarged Tonsils
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Learning Disabilities: _____
<input type="checkbox"/> Developmental: _____ |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

SPECIAL NEEDS / ISSUES THAT MAY AFFECT PATIENT OR TECHNOLOGIST COMFORT/SAFETY:

- | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Tape, Latex, Talc or other Allergies: _____
<input type="checkbox"/> Medication Adverse Reactions: _____
<input type="checkbox"/> Psychiatric Problems that may affect study (Specify): _____ | <input type="checkbox"/> Head Banging or Rocking
<input type="checkbox"/> Walker, Wheelchair, Assistance Walking
<input type="checkbox"/> Translator - Language: _____

Medications: Technologists may NOT administer oral or injectable medication in the lab. The patient's medications can only be self-administered. |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

I authorize Emerson Hospital Sleep Disorders Program to conduct the above named study.

Requesting Physician: _____ NPI: _____

Signature: _____ Phone: _____

EMAIL ADDRESS: _____ Date: ____/____/____

DIRECTIONS

**Emerson Hospital
133 Old Road to Nine Acre Corner (ORNAC)
Concord, MA 01742**

After hours Sleep Center Phone Number: 617-823-6635

To reach the Sleep Center on the evening of your study after 7:00p.m. (i.e. running late, lost, etc.), please use the number listed above.

From the East

From Route 95/128, take the exit for Route 2 West. Follow Route 2 West to Concord. Route 2 takes a sharp turn to the left at the intersection of Route 2A (at the bottom of the hill). Stay on Route 2 past two more intersections (Walden Pond/Route 126 and Sudbury Road.) Take your next left at the lights. The Emerson Hospital entrance will be on the left.

From the West

Take Route 2 East or 2A/119 East to the Concord rotary. Follow Route 2 East for approximately another mile, through 3 sets of lights. We are located immediately after Route 62, on the right.

Parking

The entrance to the parking garage is located opposite the main entrance of the hospital. Park on Level 1 or above. There is no charge for parking if you leave before 7:00 a.m. the morning after your test. Otherwise, the charge is approximately \$6.00.

ONCE YOU ARRIVE AT EMERSON HOSPITAL

Go in the main entrance of the hospital and check in if you haven't pre-registered. From the main entrance of the hospital, go down the hall, past the red Bank of America ATM and take your first left. Look for the North elevators. Take elevator A to the 4th floor. Exit the elevator and take a left at the glass window. Go through the double doors and take a right at the reception desk. The Sleep Center is located in the rooms on the left. The Sleep Center is approximately 30 feet from the elevators.