



NHH Sleep Lab Order Form

Patient Legal Name: _____ Date of Birth: _____
 Last First MI MM DD YY

PLEASE PRINT

Signs / symptoms (medical necessity): (Check all that apply) <input type="checkbox"/> Excessive Daytime Sleepiness/Hypersomnolence <input type="checkbox"/> Snoring <input type="checkbox"/> Nocturnal Desaturations <input type="checkbox"/> Choking/Gasping during sleep <input type="checkbox"/> Restless sleep <input type="checkbox"/> Witnessed Apnea <input type="checkbox"/> Disturbed Sleep <input type="checkbox"/> Fatigue <input type="checkbox"/> Depression <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Other: _____	Appointment (date/time): Arrival Time: <input type="checkbox"/> Memory Loss <input type="checkbox"/> AM Headaches <input type="checkbox"/> Restless Legs <input type="checkbox"/> Hypoxia <input type="checkbox"/> Obesity <input type="checkbox"/> Abnormal Weight Gain <input type="checkbox"/> Irritable/Nervousness <input type="checkbox"/> Pulmonary Hypertension <input type="checkbox"/> Chronic Obstructive Pulmonary Disease <input type="checkbox"/> Hypertension	Initials _____
Tests / therapy requested: <input type="checkbox"/> Sleep Study (polysomnogram) <input type="checkbox"/> CPAP Study <input type="checkbox"/> MWT with urinalysis <input type="checkbox"/> MSLT with urinalysis <input type="checkbox"/> May use oxygen if needed		
Special instructions: <input type="checkbox"/> Nothing to eat or drink after midnight <input type="checkbox"/> No prep <input type="checkbox"/> Other _____		

Signs / symptoms (medical necessity): Tests / therapy requested: Special instructions:	Appointment (date/time): Arrival Time: <input type="checkbox"/> Nothing to eat or drink after midnight <input type="checkbox"/> No prep <input type="checkbox"/> Other _____	Initials _____
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BUN & Creatine required within the last 30 days if applicable. BUN _____ Date Done _____ Creatine _____ Date Done _____	<input type="checkbox"/> To be drawn at hospital <input type="checkbox"/> Drawn at _____
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Physician's Signature _____ Physician's ID # _____ Date: MM DD YY

Please check one:

- BryanLGH Medical Center East/Off-site Locations-Lincoln, NE
Scheduling Center: 402-481-8550 Fax: 402-481-8528
- BryanLGH Medical Center West/Off-site Locations-Lincoln, NE
Scheduling Center: 402-481-5121 Fax: 402-481-5177
- Saint Elizabeth Regional Medical Center-Lincoln, NE
Care Office: 402-486-7123 Fax: 402-486-8719
Cherry Hill Clinics: 402-486-7454 Fax: 402-486-8007
PT/OT West: 402-475-6656 Fax: 402-475-6685
Wound Center: 402-486-8770 Fax: 402-486-8771
- Madonna Rehabilitation Hospital-Lincoln, NE
Main Campus: 402-483-9534 Fax: 402-483-9494
- North Clinic: 402-434-5905 Fax: 402-483-5902
- Nebraska Heart Hospital-Lincoln, NE
Scheduling Center: 402-328-3050 Fax: 402-328-3261

Name of person filling out form