SLEEP CENTER
*Orange County*
4980 Barranca Pkwy, Ste. 170, Irvine, CA 92604

**Accredited by the American Academy of Sleep Medicine**

**Wesley Elon Fleming, M.D.**
Board Certified in Sleep Medicine
Board Certified in Neurology
Member, American Academy of Sleep Medicine

**949.679.5510 tel 949.679.1080 fax**
**www.sleepcenteroc.com**

# Sleep Center Order Form

Patient Name:_____ DOB:_____

Phone (H)_____ (W) _____ (Cell)_____

Ordering Provider Name: _____Phone _____Fax_____

Ordering Provider Section (please CHECK):

**Urgency:** ❑ Next Available ❑ Urgent

**Signs/Symptoms:**
❑ Loud snoring ❑ Frequent Awakenings ❑ High B/P
❑ Witnessed apnea ❑ Restless Sleeper ❑ Heart disease
❑ Daytime sleepiness ❑ Obesity ❑ Lung disease
❑ Other (specify) _____

**Diagnosis for test:**
❑ 780.09 Somnolence ❑ 327.23 Sleep apnea
❑ 347 Narcolepsy ❑ 780.59 Other sleep disturbance
❑ 327.00 Insomnia ❑ Other (specify) _____

**Service requested:**
❑ Sleep clinic consultation (Specialist evaluation, testing, and treatment as needed)
❑ Split-Night Sleep Study (NPSG + CPAP/BiPAP on same night if criteria met)
❑ Diagnostic sleep study (nocturnal polysomnogram – NPSG)
❑ CPAP/BiPAP study (continuous or bi-level positive airway pressure titration)
❑ Home sleep study
❑ Free overnight pulse oximeter
❑ Other sleep study (specify)_____

Signature of Ordering Provider: X_____ Date_____

If a sleep clinic consultation is not desired, then the sleep study results will be faxed to you in order to notify the patient and ensure follow-up.

❑ Check if supplemental oxygen should not be used if needed

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**Please fax the following information to the Sleep Center:**

❑ This form completed and signed ❑ Patient's insurance and demographic information

## Fax: 949-679-1080

**Please notify us if patient is physically disabled.*