



One Medical Center Drive
P.O. Box 626
Biddeford, ME 04005-0626
(207) 283-7000

SMMC Sleep Lab

Scheduling: (207) 283-6888
FAX: (207) 282-4479

Physician Order for Polysomnogram (PSG)

Name of Patient: _____ Date of Birth: _____

Type of Test Requested

- Diagnostic PSG only
- Split Night PSG (Diagnosis PSG & Treatment PSG if lab criteria met)
- CPAP may be ordered following therapeutic PSG according to SMMC protocol
- I will be responsible for treatment
- CPAP / BiPAP / O2 Titration PSG
- Diagnostic PSG with MSLT
- VPAP ADAPT SV
- Mask Fitting/Acclimation

Suspected Diagnosis

- Obstructive Sleep Apnea (OSA)
- Restless Legs Syndrome / Periodic Limb Movements
- Circadian Rhythm / Sleep Phase Disease
- REM Behaviour Disorder / Parasomnia
- Insomnia Complaint
- Narcolepsy
- Other: _____

Sleep History and Physical

A. Symptoms (check all that apply)

- Excessive Daytime Somnolence
- Snoring
- Witness Pauses in Breathing
- Inappropriate Sleep Episodes
- Cognitive Impairment
- Inattention Vehicular Accidents
- A.M. Headaches
- Wakes up Short of Breath
- Memory Impairment

B. Medical Findings (check all that apply)

- Reduced Pharyngeal Caliber
- Obesity
- Diabetes
- Cyanosis
- Palatial / Mandibular
- Abnormalities
- Edema
- EKG Evidence of LVH
- Congestive Heart Failure
- HTN
- CNS injury
- Non-Ambulatory

C. Physical Exam

Neck Size: _____ cm Height: _____ cm Weight: _____ kg BMI: _____

Please include the following with your referral:

- Allergies
- Recent Medications
- History and Physical

Special Needs: (check all that apply)

- Needs caregiver
- Hoyer lift
- Interpretive services
- Access to shower in a.m.

Signature of Physician: _____ MD / DO Date: _____ Date of PSG: _____ Time: _____