



1006 Treetops Blvd., Suite 102 | Flowood, MS 39232 | Phone: 601-939-1808 | Fax: 601-939-3828
www.somnussleepclinic.com

PLEASE NOTE

It is very important that the following be faxed to (601)939-3828:

- (1) H&P
 - (2) Progress Notes describing the patient's sleep complaints and medical conditions
 - (3) Insurance cards (FRONT AND BACK)
 - (4) Daytime contact number
-

Order Form

Patient Name: _____

Chief Complaint:

- snoring
- witnessed apneas
- restless sleep
- excessive daytime sleepiness
- interrupted sleep
- awakenings gasping
- drowsy driving
- fatigue

Does your patient require:

- Supplemental O2? (___ L/min)
- Assistance needed/handicapped
- Sleep Medication

Physician Order: (please check all that apply)

- Office Consultation for _____ (please indicate)
- PSG to evaluate for Obstructive Sleep Apnea. A CPAP titration will be scheduled afterwards if clinically appropriate.
- CPAP Titration
- Direct PSG (BCBS of MS ONLY with supporting documentation of known OSA symptoms)

Requested Follow-up after sleep study:

- Make an appointment with Somnus Sleep Clinic
- I will schedule the patient a follow-up appointment with myself.

Referring Physician Signature

Date

ASSOCIATE MEDICAL DIRECTOR'S Verification of Orders:

Brenda Hines, MD



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VERY IMPORTANT: PLEASE INCLUDE RECENT CLINICAL NOTE