

**eRiver Comprehensive Sleep Disorders Lab**  
Sleep Study Requisition Form

eRiver Comprehensive Sleep Disorders Lab  
67 Prospect Ave.  
Hudson, NY 12534  
Ph: 518-822-8181  
Fax: 518-822-8010

Dear Doctor:

Thank you for referring your patient to our facility. Please check mark the information in each section and fax this requisition back to us. This will be considered your prescription for this patient's test.

**As per eRiver Sleep Lab protocol, this form must be completed in full prior to testing.**

**PATIENT'S NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**CITY:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**PHONE NUMBER:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

**PRIMARY INSURANCE:** \_\_\_\_\_ **SECONDARY** \_\_\_\_\_

**SIGNIFICANT MEDICAL CONDITIONS:**

Hypertension \_\_\_\_\_ Diabetes \_\_\_\_\_ Heart Disease \_\_\_\_\_ COPD \_\_\_\_\_

**OTHER:** \_\_\_\_\_

**PLEASE CHECK APPLICABLE SYMPTOMS:**

_____ Excessive Daytime Somnolence	_____ Cataplexy	_____ Fatigue
_____ Sleep Attacks	_____ Snoring	_____ Height
_____ Cramps in Legs	_____ Stop Breathing at Night	_____ Weight
_____ Numbness/Tingling in legs	_____ Morning Headaches	_____ BP
_____ Wake feeling unrefreshed	_____ Hypertension	
_____ Unusual Behaviors	_____ Other	

**MEDICATIONS:** \_\_\_\_\_

*Fax list if available*

**MEDICATION ALLERGIES:**

*If unusual behaviors are noted, please include description in the clinical notes*

**UPPER AIRWAY EXAM:** \_\_\_\_\_

**SYSTEMS EXAM:** \_\_\_\_\_

**BRIEF CLINICAL DESCRIPTION:**

**PROCEDURE: CHOOSE ONLY ONE**

\_\_\_ PSG \_\_\_ PSG/MSLT (R/O Narcolepsy) \_\_\_ MWT \_\_\_ CPAP Titration \_\_\_ BIPAP Titration

\_\_\_ Sleep Consultation with physician

*Special instructions:* \_\_\_\_\_

REFERRING PHYSICIAN'S SIGNATURE \_\_\_\_\_

PRINT NAME \_\_\_\_\_

OFFICE PHONE: \_\_\_\_\_ OFFICE FAX: \_\_\_\_\_

AUTHORIZATION # (if available): \_\_\_\_\_

**Please send a copy of patient's insurance information**