

The Sleep Disorder Center of Olean General Hospital
Olean, NY 14760
Phone (716)373-9300 Fax (716)373-9302

INFORMATION FOR DIRECTLY REFERRED PATIENTS

Please complete this form (after the patient encounter) and submit it along with the Sleep Study Order form for the patient you would like scheduled. After review of the information by a sleep staff physician, the patient will be called to schedule a sleep study. You will receive a courtesy letter by fax to let you know the date and time of your patient's sleep study. If you do not receive this courtesy letter within two days of sending us your forms, please call us to ensure we have received them. If you do not receive this courtesy letter within two days of sending us your forms, please call us to ensure we have received them. Also, please retain a copy of this history and physical form in the patient's medical record.

Name: _____ Birth Date: _____

PHYSICAL EXAM: Age: _____ Height: _____ Weight: _____ Gender: M F

ENT:	Normal _____	Abnormal: _____
Lungs:	Normal _____	Abnormal: _____
Cardiac	Normal _____	Abnormal: _____
Abdomen:	Normal _____	Abnormal: _____
Extremities:	Normal _____	Abnormal: _____

HISTORY OF SLEEP PROBLEMS:

- | | |
|---|--|
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Nocturia |
| <input type="checkbox"/> Witnessed apneas | <input type="checkbox"/> Shift work |
| <input type="checkbox"/> Excessive daytime sleepiness | <input type="checkbox"/> Cataplexy |
| <input type="checkbox"/> Morning Headaches | <input type="checkbox"/> Sleepwalking |
| <input type="checkbox"/> Sleep paralysis | <input type="checkbox"/> Restlessness while asleep |
| <input type="checkbox"/> Difficulty initiating or maintaining sleep | |
| <input type="checkbox"/> Urge to move legs at night | |
| <input type="checkbox"/> Other _____ | |

Comments: _____

MEDICAL CONDITIONS:

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Cardiac arrhythmias - what type? _____ | |
| <input type="checkbox"/> CHF | <input type="checkbox"/> GERD |
| <input type="checkbox"/> ALS | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Stroke/Weakness | <input type="checkbox"/> Asthma/COPD |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Chronic Pain |
| <input type="checkbox"/> Pacemaker or defibrillator | <input type="checkbox"/> Fibromyalgia |

Comments: _____

Does your patient have any special needs?" if so, please list: _____

Physician requesting sleep study: _____

Signature: _____ Date: _____

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OLEAN, NY 14760

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101 N. Main St, Hampton Inn Rm 323, Olean, NY 14760

HISTORY AND PHYSICAL