Pulmonary Function and Home Sleep Study Requisition
10501 North Central Expressway, Suite 101
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214-363-8447 FAX 214-396-1909

Patient: _____Date:_____
Last First

Diagnosis: _____ Date of Birth: _____
Month Day Year

Referring Physician: _____ UPIN: _____

Fax: _____-_____-_____ Telephone: _____-_____-_____

This patient does NOT have a contraindication to receiving inhaled bronchodilators associated with testing. _____

Referring Physician Signature

TEST OPTIONS

Full pulmonary functions including spirometry before and after inhaled bronchodilators, residual volumes, total lung capacity, diffusion capacity, airway resistance and specific airway conductance: ____

Spirometry before and after inhaled bronchodilators: ___

Maximum voluntary ventilation or MVV: ___

Home sleep monitoring, level 4 screening for sleep apnea: __ . Please complete Bang Questionnaire when ordering home sleep monitoring.

STOP –Bang Questionnaire

	Yes	No
Snoring? Do you snore loudly (loud enough to be heard through closed doors or your bed partner elbows you for snoring at night?		
Tired? Do you often feel Tired, Fatigued, or Sleeping during daytime (such as falling asleep during driving?		
Observed? Has anyone Observed you Stop Breathing or Choking/Gasping during your sleep?		
Pressure? Do you have or are you being treated for High Blood Pressure?		
Body Mass Index more than 35 kg/meter squared?		
Age older than 50 years?		
Neck size large? (Measured at the Adams apple) Males 17 inches or larger, Females 16 inches or larger		
Gender=Male		

Low risk of OSA: Yes to 0-2 questions
Intermediate risk of OSA: Yes to 3-4 questions
High risk of OSA: Yes to 5-8 questions