

MSLT/MWT Sleep Study Worksheet

Patient Name _____ DOB _____ Age _____

Health Plan _____ Member Number _____

Requesting Physician _____ Sleep Study Provider _____

Directions:

Collect patient information from the requesting physician. Submit online (www.ProviderPortal.com) for an instant response.

Diagnostic Sleep Study Type (check one): MSLT/MWT

Has the patient previously had a MSLT or MWT study? Yes No

Primary Suspected Diagnosis _____

Sleep Study History

Previous MSLT/MWT did not provide diagnosis of narcolepsy: Yes No Unknown

Signs and Symptoms

(please select all that apply)

Daytime hypersomnolence for at least eight weeks

At least one of the following:

Disrupted nocturnal sleep

Cataplexy

Hallucinations

Sleep Paralysis

Difficult morning awakening

Prolonged night sleep

Sleep drunkenness

Frequent non-refreshing daytime naps



MSLT/MWT Sleep Study Worksheet

continued

Has the patient previously had a MSLT Or MWT study? Yes x No

Primary Suspected Diagnosis _____

Sleep Study History

Previous MSLT/MWT did not provide diagnosis of narcolepsy: Yes No Unknown (due to no previous sleep testing or patient tested negative for OSA)

Signs and Symptoms

(please select all that apply)

Daytime hypersomnolence for at least eight weeks

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