SOUNDSLEEP
SOLUTIONS
Helping Families Sleep Better

Polysomnography, MATRx & Sleep Services Requisition Form

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PATIENT INFORMATION or OFFICE STAMP

Name: ______________________________

PHN: ______________________________

DOB: ____________ (MM/DD/YY) Gender: Male ☐ Female ☐

Parent's Names: ______________________________

Phone #: ______________________________

Address: ______________________________

REFERRING DDS or MD or OFFICE STAMP

Name: ______________________________

PRAC ID: ______________________________

Address: ______________________________

Phone #: ______________________________

Fax #: ______________________________

Email: ______________________________

Referral for:

☐ MATRx Titration Polysomnography (Level III conducted prior to MATRx study)
☐ Level III Test (MATRx Titration Polysomnography if indicated)
☐ Level III Test
☐ SSS to facilitate fabrication of Oral Appliance if indicated

Notes: Please provide previous sleep study reports if available. Measurements are done with MATRx Trays & Scale.

☐ Range of Motion: ______________
☐ Maximum Retrusion: ______________
☐ Maximum Protrusion: ______________
☐ Overjet: ______________

History of Sleep Problems/Clinical History: (check one or more boxes)

☐ Snoring/Apneas
☐ Excessive daytime sleepiness
☐ Enuresis/bed wetting
☐ Sleepwalking/night terrors
☐ Frequent wakening
☐ Behavioral/emotional/neurocognitive
☐ Falling asleep/staying asleep
☐ Psychiatric conditions
☐ Restless legs syndrome
☐ Nightmares
☐ Circadian rhythms (shifted clock)
☐ Other: ______________

Medical Conditions: (check one or more boxes)

☐ Asthma/Allergies
☐ Attention Deficit Hyperactivity Disorder (ADHD)
☐ Syndromes - Down/Craniofacial/Genetic
☐ Obesity
☐ Had tonsils/Adenoids removed
☐ Recurrent tonsillitis
☐ Gastroesophageal reflux
☐ Seizures
☐ Other: ______________

Current Medications:

____

Medications to be stopped for study:

____

Some fees are not covered by AHC

Physician's Signature: ______________________________

Date: ____________ (MM/DD/YY)

OFFICE USE ONLY

Appointment Date: ____________ (MM/DD/YY)

Approved by: ______________________________

Sound Sleep Solutions shares office space with Respiratory Homecare Solutions

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