



RAJIV M. JOSEPH, M.D., Ph.D., F.A.A.N.

NEUROLOGY & SLEEP MEDICINE

www.DallasNeurology.com • www.SleepDisordersClinic.com

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REQUEST FOR EVALUATION

Date: _____

Referring Physician: _____ Tel: _____ Fax: _____

Diagnosis/ Symptoms (Suspected): _____

PATIENT INFORMATION:

Name: _____ DOB: _____

SSN: _____ Gender: M / F

Address: _____

Home: () _____ Work: () _____ Cell: () _____

INSURANCE: _____ Phone: _____

Policy #: _____ Group #: _____

I. SLEEP STUDIES:

- Consultation with Dr Joseph, appropriate sleep studies and treatment
- Sleep study on the first night, and CPAP titration on a subsequent night (if necessary)
- CPAP titration only (please send a diagnostic polysomnogram positive for apnea)
- (MSLT) Multiple Sleep Latency Test
- SPLIT NIGHT
- (MWT) Maintenance of Wakefulness Test
- (HST) Home Sleep Test-only if required by insurance

II. DME/CPAP SETUP: YES NO

III. DME SUPPLIES: YES NO

IV. EMG/NCS STUDIES: UPPER LIMBS LOWER LIMBS

V. NEUROLOGY CONSULT: YES NO

Referring Physician's Signature: _____ Date: _____