Better Sleep Inc.
with Dr. Alina Lyons

Physician Order Form

Patient Name:	Date of Birth:
Patient Phone #:	Email Address:

Order: ☐ Consultation with Dental Evaluation ☐ Home Sleep Study

Patient's Medical History:

Please check the associated symptoms (if applicable):

☐ Snoring	☐ Headaches	☐ Hypertension
☐ Excessive Daytime Sleepiness	☐ Poor Sleep	☐ History of Stroke
☐ Unspecified Sleep Disorders	☐ Gasping for air	☐ Congestive Heart Failure
☐ Mood Disturbances	☐ Obesity	☐ Coronary Heart Disease
☐ Diabetes	☐ GERD	☐ Sexual Dysfunction

Additional Symptoms:_____

Suspected Diagnosis (please check):

☐ Obstructive Sleep Apnea	☐ Narcolepsy
☐ Sleep Apnea	☐ Insomnia
☐ Sleep Related Movement Disorder	☐ Parasomnia

For the Request of the Sleep Study Order:

I certify that the above home sleep test is medically indicated as it is reasonable and necessary with reference to the standards of medical practice and treatment of the patient's medical condition.

Better Sleep Inc. Referral Fax Line: 609-438-1938
Appointment Line: 609-438-1061
A Better Sleep team member will contact your patient for an appointment

Physician/PA/CRNP Name:	
Signature:	Referring Physician Direct Line: