SLEEP DIAGNOSTIC CENTER

PAP ENCOUNTER FORM

Patient:	
DOB:	Physician:
Phone:	Physician Phone#:
	Physician Fax:

Test Ordered		______________________
Scheduled Date		______________________
Arrival Time		______________________
Bedroom Used		______________________
Technician		______________________

Special Instructions: ____

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PAP Therapy Status: ☐ accepted ☐ waiting to see physician ☐ refused	
PAP level:	Mask:

EPSS	Height	Weight:	BMI:	AHI=

Insurance:

Interpreting Physician: ____________________

PT.

MR.#/RM.

DR.