

## SLEEP STUDY PHYSICIAN ORDER FORM

New referral       5-year sleep study renewal

PATIENT INFORMATION			
Name:		Address:	
City:	State:	Zip:	DOB:
Phone number:	Alt phone #:		SSN:
Primary insurance:		Subscriber:	
ID number:	Group number:		DOB:
Secondary insurance:		ID number:	

**\*\*PLEASE FAX COPY OF INSURANCE CARD(S)\*\***

PATIENT MEDICAL HISTORY	CONTRA-INDICATIONS FOR UNATTENDED STUDY (PER AMERICAN ACADEMY OF SLEEP MEDICINE)
<input type="checkbox"/> Snoring – R06.83 <input type="checkbox"/> Daytime Sleepiness/Somnolence – R40.0 <input type="checkbox"/> Obesity – E66.01 <input type="checkbox"/> Hypersomnia Unspec. (excessive sleepiness) – G47.13 <input type="checkbox"/> Insomnia w/Sleep Apnea Unspecified – G47.10 <input type="checkbox"/> Periodic Limb Movement – G47.61 <input type="checkbox"/> Persistent disorder of Maintaining sleep – F51.01 <input type="checkbox"/> Obstructive Sleep Apnea – G47.33 <input type="checkbox"/> Primary Central Sleep Apnea – G47.37 <input type="checkbox"/> Respiratory Abnormality – R06.0 <input type="checkbox"/> Sleep Disturbance, Unspec. – F51.3 <input type="checkbox"/> Narcolepsy or Cataplexy – G47.419 <input type="checkbox"/> Diabetes – E08.9 <input type="checkbox"/> Hypertension – I10 <input type="checkbox"/> Heart Condition – I51.9 <input type="checkbox"/> COPD – J44.9 <input type="checkbox"/> Oxygen dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Noc <input type="checkbox"/> Cont <input type="checkbox"/> Other: _____	<input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Prior CVA, TIA, Seizure <input type="checkbox"/> Intractable Hypertension <input type="checkbox"/> Neuromuscular disorder <input type="checkbox"/> Obesity-Hypoventilation Syndrome <input type="checkbox"/> Low daytime SaO2 <input type="checkbox"/> Patient on high dose narcotics <input type="checkbox"/> Patient on 24-hr supplemental oxygen <input type="checkbox"/> Severe Pulmonary disease (COPD) <input type="checkbox"/> Suspect Narcolepsy, Central SA, PLMD, Circadian disorder, Parasomnia <input type="checkbox"/> Pt unable to follow instructions (cognitive impairment) <input type="checkbox"/> Previous HST which did not diagnose OSA in pt with ongoing clinical suspicion for OSA <input type="checkbox"/> Patient under age 18 years <input type="checkbox"/> Physical or psychological disability

TESTING	
<input type="checkbox"/> PSG Sleep Study – 95810 (test for sleep apnea) <input type="checkbox"/> CPAP Titration – 95811 (determine pressure needed for CPAP/BiPAP) <input type="checkbox"/> Home Sleep Test – 95806 (test for sleep apnea while at home)	<input type="checkbox"/> Overnight Pulse Oximetry –94621/94762 (oxygen saturation test) <input type="checkbox"/> MSLT Test w/ PSG – 95805 and 95810 (test for Narcolepsy) <input type="checkbox"/> 6-min Walk Test (Daytime) – 94618 <input type="checkbox"/> Other: _____

INTERPRETING PHYSICIAN		
<input type="checkbox"/> Dr. Michael Davis	<input type="checkbox"/> Dr. Ajitpal S. Sethi	<input type="checkbox"/> No preference

ORDERING PHYSICIAN		
Physician Name:	Physician Signature:	Date:
Address:	Phone number:	NPI:
	Fax number:	