

Order Form For Sleep Diagnostic Services

Patient Demographic Information

Last Name _____ First Name _____
 _____ / _____ / _____ Male Female
 Date of Birth
 Address _____

 City _____ ST _____ ZIP _____
 _____ _____
 Home Tel _____ Work/Cell Tel _____
 _____ ' _____ " _____ lbs. _____ inches
 Ht _____ Weight _____ Neck size _____
 SSN: _____ - _____ - _____

Referring Physician

Physician Name _____ Title _____
 _____ _____
 Office Tel _____ Office Fax _____
 Address _____

 City _____ ST _____ ZIP _____

 UPIN # _____ License # _____ NPI # _____
 Specialty: _____ Ofc Contact _____
 Date of Order _____ / _____ / _____ Sales Rep: 11

Insurance Information

HMO PPO POS _____
 Please fax copy of Insurance card(s), H&P, and the physician's clinical notes related to this referral.
 Payor _____
 Member ID _____
 Group # _____ Auth # _____

Patient Clinical Information

Chief Complaint/Dx: _____

 Insomnia Obstructive Sleep Apnea
 Snoring Excessive Daytime Sleepiness
 Narcolepsy Restless Legs Syndrome
 Sleepwalking Periodic Limb Movements
 Other: _____
History of Illness (Please check all that apply):
 Hypertension CHF COPD
 Cardiac Arrhythmia Oxygen Use _____ (lpm)
 If your patient uses oxygen, please advise if study is to be performed with oxygen (only) or room air:
 Oxygen Only Room Air
 Other Clinical Issues _____
 Allergies _____
 Medications: _____

Consult Or Sleep Study Order

Requested Service	CPT Code
<input type="checkbox"/> Consultation By a Board Certified Sleep Specialist	99245
<input type="checkbox"/> Diagnostic Polysomnography (PSG) Attended sleep study performed in lab	95810
<input type="checkbox"/> Pre- or Post-Operative Polysomnography Monitor symptoms or improvement of OSA	95810
<input type="checkbox"/> Split-Night Polysomnography Combination of Diagnostic and CPAP Trial in one overnight sleep study, if indicated	95811
<input type="checkbox"/> Multiple Sleep Latency Test (MSLT) Daytime testing preceded by Diagnostic PSG (95810) to rule out or rule in Narcolepsy	95805
<input type="checkbox"/> Ambulatory (Home) Diagnostic PSG Unattended polysomnography, 4 or more parameters, conducted at patient's home	95806
<input type="checkbox"/> Ambulatory (Home) Auto-Titration Unattended auto-titration, if indicated by the PSG, conducted at the patient's home	94660
<input type="checkbox"/> Pulse Oxymetry Unattended monitoring of oxygen saturation while patient is asleep, at patient's home	94760
<input type="checkbox"/> To be determined by Sleep Specialist	_____
<input type="checkbox"/> Provide CPAP Unit and Supplies Home treatment of diagnosed sleep apnea. See attached treatment recommendations provide therapeutic pressure	