Beth Israel Lahey Health
Beth Israel Deaconess Milton

Sleep Testing oneForm Request

Please fax completed form with most recent office notes to: 617-796-9099
For questions, please call: 617-796-7766
PLEASE NOTE: Orders cannot be processed without the most recent office notes submitted

DEMOGRAPHIC INFORMATION

Patient Name:_____DOB:_____ English Proficient? □ Yes □ No

Patient Phone Numbers: Mobile #: _____ Home#: _____ Alternate #: _____

Insurance Provider:_____Insurance ID #: _____

SLEEP STUDY REQUESTED

☐ **Polysomnography (95810):** All night attended diagnostic sleep study (PSG) to evaluate for all sleep disorders.

☐ **Split Night (95811)":** Attended diagnostic testing including CPAP initiation & titration. If titration criteria met with less than three hours testing remaining, a new order for an all-night PAP titration study will be required. Refer to interpretation report.

☐ **PAP Titration* (95811**): Titrate positive airway pressure to optimal pressure level.
*OSA must be previously documented by a PSG. **Date of PSG:** _____

☐ **Inspire (G47.33)** Date of implant: _____

☐ **Home Sleep Apnea Test (HSAT) :** Unattended diagnostic testing. Recommended ONLY for patients with high likelihood of Obstructive Sleep Apnea (OSA). Provider: Neurocare, Inc. (TIN: 043032581)

If the in-lab study is not approved and a Home Sleep Test is offered, I authorize the HST as a substitution unless "NO" is selected ☐ NO

SPECIAL NEEDS/ASSISTANCE (please specify)

☐ Supplemental Oxygen (if selected, HSAT cannot be performed)

INDICATION (suspected sleep disorder)

☐ Obstructive Sleep Apnea (G47.33) ☐ Narcolepsy (G47.419) ☐ Periodic Limb Movements (G47.61)
☐ Central Sleep Apnea (G47.31) ☐ REM Behavior Disorder (G47.52) ☐ Other: _____

PATIENT COMPLAINTS (select at least one)

☐ Excessive daytime sleepiness ☐ Frequent arousals/disturbed or restless sleep
☐ Disruptive snoring ☐ Not refreshed or rested after sleeping

SYMPTOMS (select at least two)

☐ Witnessed apneas ☐ Enlarged tonsils / physiological abnormalities compromising respiration ☐ Bruxism/teeth grinding during sleep ☐ Hypertension
☐ Waking up gasping/choking ☐ Leg/arm jerking ☐ Nocturia ☐ Irritability
☐ Decreased concentration ☐ Decreased libido ☐ Other:
☐ Memory Loss

***Duration of Symptoms:**
□ < 2 months □ > 6 months
□ > 2 months □ > 1 year

DOCUMENTED COMORBIDITIES & MEDICAL HISTORY: REQUIRED FOR LAB STUDIES ONLY

☐ Critical illness or physical impairments preventing use of portable HST device
☐ Moderate to severe Congestive Heart Failure
☐ History of Myocardial infarction
☐ History of stroke Date:_____
☐ Moderate to severe pulmonary disease
☐ O2 at night
☐ Neuromuscular weakness affecting respiratory function or impairing activity (please specify:) _____
☐ Patient prescribed opiates: _____
☐ Polycythemia
☐ Other:

I acknowledge that the clinical information submitted to support this request is accurate and specific to this patient, and all information has been provided. I authorize submission of this information for precertification on my behalf.

Ordering Provider Signature:_____Date: _____

Print Name:_____NPI: _____