

DEMOGRAPHIC INFORMATION

Patient Name: _____ DOB: _____ English Proficient? Yes No

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

Insurance Provider: _____ Insurance ID #: _____

Has patient had previous testing? Yes (Study report must be submitted if completed at another facility) No/Unknown

If yes, please specify reason for re-testing: _____

SLEEP STUDY REQUESTED

- Polysomnography – PSG (95810):** Attended 18-channel diagnostic testing. CPAP will not be initiated.
- Split Night Study (95811):** Attended 18-channel 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.
 Diagnosis Confirmed by PSG. **Date of PSG:** _____
 CPAP Bi-level PAP* ASV* (for previously diagnosed complex and central sleep apnea)
- Home Sleep Apnea Test – HSAT –** Unattended Type 3 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 (If applicable, please specify)

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

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
- History of Myocardial infarction (s/p 3 mo.)
- Patient prescribed opiates: _____
- Moderate to severe Congestive Heart Failure
- History of stroke (Date: _____)
- Polycythemia
- Neuromuscular weakness affecting respiratory function or impairing activity (please specify: _____)
- Moderate to severe pulmonary disease
- 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: _____