

**Sleep Study Requisition**

**St. Elizabeth's Medical Center**

736 Cambridge Street, Seton 6, Boston, MA 02135

Please fax completed form with most recent office notes & Face Sheet to:

617-796-9099

For questions, please call: 617-796-7766

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ BMI: \_\_\_\_\_ English Proficient YES NO

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_ Language \_\_\_\_\_

Gender: M / F Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_ Sec Ins: \_\_\_\_\_ Policy #: \_\_\_\_\_

**REQUESTED SERVICE:** (Please select only one study below)

**Complete Care: (Consultation & Management)**

Office evaluation after diagnostic testing, and treatment with home PAP if clinically indicated (**select test below**)

**Diagnostic PSG Study (95810):** Baseline sleep study with addition of CPAP ONLY if emergency criteria is met

**Split Night Titration (95810 & 95811):** Baseline sleep study with addition of CPAP, per split-night criteria

**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

**Home Sleep Test (HSAT):** Screening test for sleep apnea

**CPAP/ BIPAP/ ASV Titration (95811):** (circle one) All night sleep study with CPAP/ BIPAP/ ASV treatment after positive diagnostic study. For BIPAP and ASV studies, CPAP must be previously proven ineffective

**MSLT (95805):** Daytime nap test following a full night diagnostic PSG

**\*Required\* Epworth Sleepiness Score**

- 0 = would never doze or sleep
- 1 = slight chance of dozing or sleeping
- 2 = moderate chance of dozing or sleeping
- 3 = high chance of dozing or sleeping

Situation Chance of Dozing or Sleeping	Scale
Sitting and reading	
Watching TV	
Sitting inactive in a public place	
Being a passenger in a car for an hour	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch (w/o alcohol)	
Sitting in traffic while driving	
Total score equals your ESS	

0-9 Average Score, normal population TOTAL \_\_\_\_\_

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

If yes, please specify reason for retesting: \_\_\_\_\_

**Suspected Sleep Disorder (s):**

- Obstructive Sleep Apnea (G47.33)
- Central Sleep Apnea (G47.31)
- Parasomnias (G47.50)/ Seizures (G40.89)
- Periodic Limb Movements (PLMS) (G47.61)
- Restless Leg Syndrome (RLS) (G25.81)
- Narcolepsy (G47.419)
- Other \_\_\_\_\_

**Patient Complaints:**

- Snoring/ Gasping/ Choking
- Excessive Daytime Sleepiness
- Unrefreshed Sleep
- Unexplained arousals/ disturbed or restless sleep

**Duration of symptoms:**

- < 2 months
- > 2 months
- > 6 months
- > 1 year

**Patient Symptoms:**

- Witnessed Apneas
- Waking up gasping/choking
- Arm/ Leg jerking
- Obese/ large neck
- Morning Headaches
- Irritability/ Moodiness
- Memory Loss
- Decreased Concentration
- Bruxism
- Seizures
- Decreased Libido
- Hypertension
- Enlarged Tonsils/Abnormalities
- Nocturia

**Documented Comorbidities & Medical History: Required for Lab Studies Only**

- CHF (Class 3 or 4)
- Critical illness or physical impairments preventing use of portable HST device
- Polycythemia
- Neuromuscular weakness affecting respiratory function or Impairing activity **please specify:** \_\_\_\_\_
- Moderate to severe pulmonary disease
- Hx of Myocardial infarction (s/p 3 mo.)
- Hx of Stroke **Date:** \_\_\_\_\_
- Patient prescribed opiates: \_\_\_\_\_
- Other: \_\_\_\_\_

**SPECIAL NEEDS:**

Oxygen, LPM \_\_\_\_\_  
 Allergies: \_\_\_\_\_  
 Wheelchair/ Ambulation difficulties: \_\_\_\_\_  
 Cognitive Impairment: \_\_\_\_\_  
 Pre-Operative: Yes / No  
 Other: \_\_\_\_\_

**Ordering Provider Information**

Name: \_\_\_\_\_ NPI \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Phone: \_\_\_\_\_ FAX: \_\_\_\_\_ EMAIL: \_\_\_\_\_