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 s tudy. 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) □ Periodic Limb Movements (PLMS) (G47.61) □ Narcolepsy (G47.419)
□ Central Sleep Apnea (G47.31) □ Restless Leg Syndrome (RLS) (G25.81) □ Other_____
□ Parasomnias (G47.50)/ Seizures (G40.89)

Patient Complaints:

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

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

Patient Symptoms:

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

Documented Comorbidities & Medical History: Required for Lab Studies Only

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

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:_____