

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 #: \_\_\_\_\_

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.
PAP Titration\* (95811): Titrate positive airway pressure to optimal pressure level.
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).

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

PATIENT COMPLAINTS (select at least one)

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

SYMPTOMS (select at least two)

- Witnessed apneas
Waking up gasping/choking
Enlarged tonsils/physiological abnormalities
Leg/arm jerking
Bruxism/teeth grinding during sleep
Nocturia
Decreased libido
Hypertension
Irritability
Decreased concentration
Memory Loss
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
Moderate to severe Congestive Heart Failure
History of Myocardial infarction (s/p 3 mo.)
History of stroke (Date: )
Moderate to severe pulmonary disease
Neuromuscular weakness affecting respiratory function or impairing activity (please specify: )
O2 at night
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: \_\_\_\_\_