



**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)
- 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: \_\_\_\_\_)
- Neuromuscular weakness affecting respiratory
- function or impairing activity (please specify: \_\_\_\_\_)
- Moderate to severe pulmonary disease
- 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: \_\_\_\_\_