SLEEP STUDY ORDER FORM

Patient's Name: ______________________ Date of Birth: __________ □ Male □ Female

Address: ____

Phone: (Home) ______________ (Cell) ______________ (Work) __________

SUSPICIOUS SYMPTOMS

- □ Observed apneas
- □ Loud snoring
- □ Excessive sleepiness
- □ Chronic fatigue
- □ Drowsy driving
- □ Leg restlessness /jerks
- □ Sleep walking/talking
- □ Nocturnal behaviors
- □ Frequent awakenings
- □ Choking/gasping during sleep
- □ Morning headaches
- □ Cataplexy/hallucinations
- □ Prior OSA diagnosis
- □ Other ______________________ ______________________

SUSPECTED DIAGNOSES

- □ Obstructive Sleep Apnea
- □ Circadian Rhythm Sleep Disorder
- □ Parasomnias
- □ Sleep-Related Movement Disorder
- □ Restless Legs Syndrome
- □ Narcolepsy
- □ Insomnia with Sleep Apnea
- □ Hypersomnia with Sleep Apnea
- □ Other ______________________

Services Requested:

- □ Comprehensive evaluation and treatment of patient for suspected sleep-related disorder. If indicated, please provide sleep study, implement therapy, monitor patient's compliance to treatment, and provide follow-up care. Please forward findings, interventions and recommendations to me when treatment is completed.
- □ Polysomnography (PSG) studies
  - □ Diagnostic study only (1 night): CPT 95810
  - □ Titration study only (1 night): CPT 95811
  - □ Diagnostic study followed by titration study if certain requirements are met (2 nights): CPT 95810 / 95811
  - □ Pediatric diagnostic study (< 6 years of age): CPT 95782
  - □ Pediatric titration study (< 6 years of age): CPT 95783
- □ Home sleep apnea test: CPT 95800, 95801, 95806 / G0398, G0399, G0400
- □ Multiple sleep latency test: CPT 95805
- □ Maintenance of wakefulness test: CPT 95805

My signature below attests to the following:

I, the referring physician, have evaluated this patient by sleep appropriate medical history (signs and symptoms, symptom duration, sleep hygiene survey) and physical examination (focused cardiopulmonary and upper airway, neck circumference, BMI) and have concerns for the presence of one or more of the above listed symptoms and suspected diagnoses. Documentation of my clinical evaluation is included with this request.

Physician's Signature: ______________________ NPI: __________ Date : __________

Print Name: ______________________ Phone: __________ Fax: __________

Address: ____

Please fax order form, patient demographics, insurance card and clinical notes to sleep clinic.

7839 Interstate 10 West, San Antonio, TX 78230 ▪ Phone: 210.520.8333 ▪ Fax: 210.520.8335