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
□ 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 : _____

Printed Name: _____ Phone: _____ Fax: _____

Address: _____

Please fax order form, patient demographics, insurance card and clinical notes to selected location.

Sleep Centers of Texas
7839 West Interstate 10
San Antonio, Texas 78230
Ph: 210-520-8333 Fax: 210-520-8335