



SLEEP STUDY ORDER FORM

PATIENT NAME: _____ DATE OF BIRTH: _____

PATIENT'S ADDRESS: _____
 (STREET) (CITY) (STATE) (ZIP CODE)

TELEPHONE NUMBER(S): _____
 (HOME) (CELL) (WORK)

INSURANCE: _____ ID NUMBER: _____ GROUP NUMBER: _____

INDICATIONS FOR TESTING {Check indication(s) that apply}

- | | | |
|---|---|--|
| <input type="checkbox"/> Loud Snoring | <input type="checkbox"/> Witnessed Apnea | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Excessive Daytime Sleepiness | <input type="checkbox"/> Nocturnal Seizures | <input type="checkbox"/> Sleep Walking |
| <input type="checkbox"/> Restless Leg/ Periodic Movements | <input type="checkbox"/> Unusual Behavior | <input type="checkbox"/> Cataplexy |

DIAGNOSIS CODES {Check code(s) that apply}

- | | | |
|---|--|--|
| <input type="checkbox"/> Obstructive Sleep Apnea - 327.23 | <input type="checkbox"/> Narcolepsy - 347.00 | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Hypersomnia with Sleep Apnea - 780.53 | <input type="checkbox"/> Hypoxemia - 799.02 | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Insomnia with Sleep Apnea - 780.51 | <input type="checkbox"/> Morbid Obesity - 278.01 | <input type="checkbox"/> Coronary Artery Disease |
| <input type="checkbox"/> Periodic Limb Movement Disorder - 327.51 | <input type="checkbox"/> Other Sleep Disturbances - 780.59 | |

ORDERS FOR POLYSOMNOGRAM (Sleep Study) TESTING {Check test(s) that apply}

* For Multiple Sleep Latency Test (MSLT)/ Maintenance of Wakefulness Test (MWT), a PSG must be performed prior to MSLT/ MWT *

- | | |
|---|---|
| <input type="checkbox"/> Diagnostic Polysomnogram (PSG) - 95810 | <input type="checkbox"/> Epilepsy/ Seizure Protocol - 95827 |
| <input type="checkbox"/> Continuous Positive Airway Pressure (CPAP)/ Bi-Level Titration - 95811 | |
| <input type="checkbox"/> MSLT/ MWT - 95805 | <input type="checkbox"/> pH Monitoring - 91034 |
| <input type="checkbox"/> Actigraphy - 95803 | <input type="checkbox"/> Other: _____ |
| For patient on home oxygen (O ₂), do study | <input type="checkbox"/> with _____ / Liters per Minute |
| Customized O ₂ orders: _____ | <input type="checkbox"/> without O ₂ |

Do patient have special needs: Yes No If yes, please specify: _____

COMMENTS/ CLARIFICATIONS: _____

HISTORY AND PHYSICAL EXAMINATION

DATE OF EXAMINATION: _____

HEIGHT:	WEIGHT:	COLLAR SIZE:	ALLERGIES:
HEENT:			NEUROLOGICAL:
<input type="checkbox"/> CROWDED OROPHARYNX	<input type="checkbox"/> LARGE TONGUE		
<input type="checkbox"/> ENLARGED TONSILS	<input type="checkbox"/> OTHER: _____		
HEART:	ABDOMEN:		
CHEST:	OTHER:		

REFERRING PHYSICIAN'S SIGNATURE _____

DATE _____ MEDICAL DIRECTOR APPROVAL (REQUIRED FOR REFERRED PATIENT)

PRINT REFERRING PHYSICIAN'S NAME _____

NATIONAL PROVIDER IDENTIFICATION NUMBER (NPI) _____

REFERRING PHYSICIAN'S TELEPHONE NUMBER _____
 SBMC199 (02/09)

FAX NUMBER _____