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Board Certified in Neurology (CN),  
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**PATIENT INFORMATION**

NAME: \_\_\_\_\_ FOLLOW-UP APPOINTMENT / SURGERY DATE \_\_\_\_\_  
GENDER: M  F   
PHONE: (HOME) \_\_\_\_\_ (CELL) \_\_\_\_\_ (WORK) \_\_\_\_\_  
DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ EMAIL: \_\_\_\_\_

**PROCEDURES**

**PEDIATRIC SLEEP PROCEDURES**

- Pediatric Diagnostic Polysomnogram
- Pediatric CPAP Titration
- Other \_\_\_\_\_

**ADULT SLEEP PROCEDURES**

- Diagnostic Polysomnogram (HST if required by insurance)
- CPAP Titration
- Split Night Study (Titration portion to be performed only if the patient meets split criteria.)
- Multiple Sleep Latency Test (MSLT) following a Diagnostic Polysomnogram
- Maintenance of Wakefulness Test (MWT)

**DIAGNOSIS**

*Must indicate at least one qualifying diagnosis:*

- G47.31** Central Sleep Apnea
- G47.33** Obstructive Sleep Apnea
- G47.30** Sleep Apnea, unspecified
- G47.61** Periodic Limb Movement Disorder
- F51.8** Sleep Related Movement Disorders, unspecified
- G47.419** Narcolepsy
- F51.13** Organic Hypersomnia/EDS
- G47.54** Parasomnias
- E66.01** Obesity Hypoventilation Syndrome
- G47.20** Disruption of 24 hr Sleep/Wake Cycle
- Other Qualifying Code** \_\_\_\_\_

**PRE-EXISTING CONDITIONS**

*NOTE: Please indicate if the following are applicable*

- Snoring
- Excessive Sleepiness
- Morning Headaches
- Pulmonary Disease (Respiratory Failure, COPD, Hypoxemia)
- Neuromuscular Disease (ALS, Parkinson's, etc.)
- Significant Cardiac Disease (CHF, Atrial Fibrillation, Pulmonary Hypertension, Arrhythmias)
- Other \_\_\_\_\_

**SCREENING**

In accordance with AASM guidelines, one of our staff sleep physicians will review the provider's clinic notes to determine if the proposed procedure conforms to AASM and current insurance guidelines.

Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ Neck Circumference \_\_\_\_\_ BMI \_\_\_\_\_ Epworth Sleepiness Scale \_\_\_\_\_

**NEURODIAGNOSTIC SERVICES**

\_\_\_\_\_ Routine EEG (Greater than 61 minutes) \_\_\_\_\_ Extended Video EEG (Greater than 14 hours)  
Diagnosis: \_\_\_\_\_ **R40.4** Transient alteration of awareness \_\_\_\_\_ **G40.90** Epilepsy, unspecified  
\_\_\_\_\_ **R55** Syncope and collapse \_\_\_\_\_ **R56.9** Other Convulsions (e.g. seizure NOS)  
Other Diagnosis: \_\_\_\_\_ \_\_\_\_\_ **R56** Convulsions

COMMENTS/SPECIAL INSTRUCTIONS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PHYSICIAN INFORMATION**

ORDERING PHYSICIAN: \_\_\_\_\_ SIGNATURE \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX \_\_\_\_\_ NPI \_\_\_\_\_

By signing you are ensuring that the physician has seen the patient face-to-face and has documented the patient's chief complaints. Please provide clinical documentation, demographics, insurance information and previous sleep studies or EEGs if applicable.