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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.)
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- 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)

Diagnosis: _____ **R40.4** Transient alteration of awareness

_____ **R55** Syncope and collapse

Other Diagnosis: _____

_____ Extended Video EEG (Greater than 14 hours)

Diagnosis: _____ **G40.90** Epilepsy, unspecified

_____ **R56.9** Other Convulsions (e.g. seizure NOS)

_____ **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.