ACADEMY DIAGNOSTICS LLC
ADULT & PEDIATRIC SLEEP CENTER

SLEEP & NEURODIAGNOSTIC DISORDERS SERVICES ORDER FORM

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AASM ACCREDITED Facility Member™

JOSHUA S. ROTENBERG, MD
Board Certified in Neurology (CN), Pediatrics, Sleep Medicine & Epilepsy

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Board Certified in Pediatrics, Pulmonology & Sleep Medicine

PATIENT INFORMATION

NAME: FOLLOW-UP APPOINTMENT / SURGERY DATE

PHONE: (HOME) (CELL) (WORK) GENDER: M ☐ F ☐

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)

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.