California Center for Sleep Disorders

San Francisco
815 Hyde Street, 3rd Floor

Daly City
295 89th St. Suite #205

Alameda
985 Atlantic Ave. Ste #250

Concord
2485 High School Ave. Ste. #218

Fremont
2299 Mowry Ave. #2

Pleasanton
2324 Santa Rita Rd, Ste. #8

Central Phone: 510-263-3300

Request for Sleep Disorders Testing & Consultation
Fax to: 510-263-3350

****** Please *ATTACH* Patient Demographics, Insurance Card, & Clinical Notes *****

Patient Name: _____ Home Phone:_____

Address: _____ Work Phone: _____

City: _____ Zip: _____ E-Mail_____ DOB: _____

Preliminary Diagnosis: ☐ OSA ☐ Snoring ☐ Insomnia ☐ Excessive Daytime Sleepiness ☐ Other: _____

Procedure Requested:

☐ **New Patient Consultation**
(CCSD will manage patient from Diagnosis to Treatment)

☐ **In Lab**
Polysomnogram
- **With follow up visit**
- **Entire night diagnostic study**
- **Diagnostic-Split *IF* criteria is met**

CPT: 95810 (Attended) EEG, EOG, EMG, EKG, Airflow, Resp Efrt, SpO2, body pos

☐ **In Lab**
PAP Titration
- **With follow up visit**
- **Patient must have prior diagnostic study**

CPT: 95811 (Attended)
CPAP / BiLevel titration

☐ **At Home**
Portable Sleep Study
- **If insurance approves**
- **Entire night diagnostic study**

CPT: 95806 (Unattended)
Cardiopulmonary and limited sleep data

☐ **In Lab**
****Split Night****
½ night diagnostic
½ night PAP titration
CPT: 95811 (Attended)
CPAP / BiLevel titration

*****SPLIT not guaranteed. If insurance required AHI and TST not met, patient will have Polysomnogram*****

Special Instructions and Requests:

****** Please *ATTACH* Patient Demographics, Insurance Card, & Clinical Notes *****

MD Name: _____

Phone # _____

Fax # _____

Address: _____

Office Stamp:

MD Signature (Required):

X _____ **Date: X** _____