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**PATIENT INFORMATION**

NAME: \_\_\_\_\_ FOLLOW-UP APPOINTMENT / SURGERY DATE \_\_\_\_\_  
GENDER: M  F

PHONE: (HOME) \_\_\_\_\_ (CELL) \_\_\_\_\_ (WORK) \_\_\_\_\_

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ EMAIL: \_\_\_\_\_

**PROCEDURES & SCREENING**

**PEDIATRIC SLEEP PROCEDURES**

- Pediatric Diagnostic Polysomnogram (Sleep Study)
- Pediatric CPAP Titration (If PSG is positive for OSA or a previous study was performed )
- Other \_\_\_\_\_

**ADULT SLEEP PROCEDURES**

- Diagnostic Polysomnogram (Sleep Study or Home test as indicated)
- CPAP Titration (If a test is positive for OSA or a previous study is available.)
- Split Night Study (Treatment portion to be performed only if the patient meets 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**

*Please indicate any of the following:*

- Pulmonary Disease** (Respiratory Failure, COPD, Hypoxemia)
- Neurological Disease** (ALS, Parkinson's, etc.)
- Significant Cardiac Disease** (CHF, Atrial Fibrillation, Pulmonary Hypertension, Arrhythmias)
- Other \_\_\_\_\_

**PRE-SCREENING**

- Ht: \_\_\_\_\_ Wt: \_\_\_\_\_
- Neck Circumference \_\_\_\_\_  BMI \_\_\_\_\_
- \*Epworth Sleepiness Scale (ESS = 10 or more)

**REFERRING PHYSICIAN PREFERENCE**

- Provide pre-test consultation with follow up evaluation & initiation of therapy as indicated
- Provide sleep apnea management if clinically indicated by testing results with consultation notes forwarded to referring provider.

**NEURODIAGNOSTIC SERVICES**

_____ Routine EEG (Greater than 61 minutes)	_____ Extended Video EEG (Greater than 14 hours)
Diagnosis: _____ <b>R40.4</b> Transient alteration of awareness	Diagnosis: _____ <b>G40.389</b> Epilepsy, unspecified
_____ <b>R55</b> Syncope and collapse	_____ <b>R56.9</b> Other Convulsions (e.g. seizure NOS)
Other Diagnosis: _____	_____ <b>R56</b> 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 sleep complaint. Please provide clinical documentation, demographics, insurance information and previous sleep studies if applicable.