Sleep Centers of Texas

SLEEP STUDY ORDER FORM

Patient's Name: _____ Date of Birth: _____ ☐ Male ☐ Female

Address:_____

Phone: (Home) _____ (Cell) _____ (Work) _____

SUSPICIOUS SYMPTOMS

☐ Observed apneas
☐ Loud snoring
☐ Excessive sleepiness
☐ Chronic fatigue
☐ Drowsy driving
☐ Leg restlessness /jerks
☐ Sleep walking/talking
☐ Nocturnal behaviors
☐ Frequent awakenings
☐ Choking/gasping during sleep
☐ Morning headaches
☐ Cataplexy/hallucinations
☐ Prior OSA diagnosis
☐ Other _____

SUSPECTED DIAGNOSES

☐ Obstructive Sleep Apnea
☐ Circadian Rhythm Sleep Disorder
☐ Parasomnias
☐ Sleep-Related Movement Disorder
☐ Restless Legs Syndrome
☐ Narcolepsy
☐ Insomnia with Sleep Apnea
☐ Hypersomnia with Sleep Apnea
☐ Other _____

☐ Evaluate and treat my patient for suspected sleep-related disorders. If a sleep study is indicated, please provide the sleep study, implement therapy as necessary, monitor my patient's compliance to treatment, and provide follow-up care. Please forward your findings, interventions and recommendations to me as the evaluation and treatment are conducted.

Request for Specific Services:

☐ Polysomnography (PSG)
- ☐ Diagnostic study only (1 night): CPT 95810
- ☐ Diagnostic study followed by titration study if certain criteria are met (2 nights): CPT 95810 / 95811
- ☐ Split-night study - partial diagnostic, partial titration (1 night): CPT 95811
- ☐ Titration study only (1 night): CPT 95811
- ☐ Pediatric diagnostic study (< 6 years of age): CPT 95782
- ☐ Pediatric titration study (< 6 years of age): CPT 95783

☐ Home Sleep Apnea Test: CPT 95800, 95801, 95806 / G0398, G0399, G0400
☐ Multiple Sleep Latency Test: CPT 95805
☐ Maintenance of Wakefulness Test: CPT 95805

My signature below attests to the following: I, the referring physician, have evaluated this patient by sleep appropriate medical history (signs and symptoms, sleep hygiene survey) and physical examination (focused cardiopulmonary and upper airway exam, neck circumference, BMI) and have concerns for the presence of one or more of the above listed symptoms and suspected diagnoses. Documentation of such is included with this request.

Physician's Signature: _____ NPI: _____ Date : _____

Print Name: _____ Phone: _____ Fax: _____

Address: _____

Please fax order form, patient demographics, insurance card and clinical notes to selected location.

☐ **San Antonio Office**
7839 Interstate 10 West, San Antonio, TX 78230
Phone: 210.520.8333 ▪ Fax: 210.520.8335

☐ **Ennis Office**
601 South Clay Street, Suite 107, Ennis, TX 75119
Phone: 972.878.7378 ▪ Fax: 972.875.8289