Elevation Respiratory Care and Diagnostics LLC.
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To request a sleep study, please email or fax your request to the above email address or fax number.

NAME OF PATIENT: _____ **DATE STUDY ORDERED:** _____/_____/_____

HEIGHT: _____inches **WEIGHT:** _____lbs. **SEX:** ___Male ___Female **DATE OF BIRTH:** _____/_____/_____

SLEEP STUDY LOCATION (FACILITY NAME): _____

FACILITY ADDRESS: _____ **Room#**_____

REASON FOR SLEEP STUDY (Please check all that apply to patient)			
___Excessive Daytime Sleepiness (EDS)	___Snoring	___ Poor Sleep	___High Blood Pressure
___Nasal Congestion/Blockage	___Wakes Up Choking	___Obesity	___Polycythemia
___Stops Breathing at Night (Observed Apneas)	___Headaches	___Reflux	
___Frequent Nocturnal Urination	___Depression	Other:	

PERTINENT EXAM (Please check all that apply to patient)			
___Enlarged Tonsils	___Redundant Soft Pallet	___ Large Uvula	___Macroglossia
___Nasal Turbinate Edema/Erythema	___Nasal Blockage	___Retrognathia	___Septal Deviation
___Nasal Mucosal Edema	___ Pulmonary Hypertension	Other:	

DOES YOUR PATIENT HAVE ANY SPECIAL NEEDS?		
___Wheelchair	___Supplemental Oxygen at _____LPM	___Interpreter (Language _____)
___Other (Please Describe):		

DOES YOUR PATIENT HAVE ANY HEART CONDITIONS?
___No ___Yes (Please Describe):

TYPE OF SLEEP STUDY REQUESTED

___ **Type 3 Sleep study, unattended, simultaneous recording: heart rate, oxygen saturation, respiratory analysis (eg, by airflow or peripheral arterial tone), and sleep time. Utilized to establish diagnosis of OSA**
- **(CPT Code 95800)**

___ **Type 3 Sleep study on Auto PAP, unattended, simultaneous recording: heart rate, oxygen saturation, respiratory analysis (eg, by airflow or peripheral arterial tone), and sleep time. Study conducted while patient on Home Auto CPAP Machine. Utilized to determine therapy efficacy while on PAP Settings: Minimum PAP -_____Maximum PAP----------**

SLEEP STUDY IS TO BE PERFORMED WITH THE PATIENT ON:

Room Air Only Supplemental O2 LPM***

***** If baseline data is collected with the patient on supplemental oxygen instead of room air, breathing events may not cause oxygen saturations to 4% or greater as required by Medicare/Medicaid (plus a few additional insurance plans) to qualify the patient for nasal PAP titration/therapy regardless of sleep apnea/hypopnea severity. For this reason, a room air baseline is recommended unless there are safety issues or other issues requiring the patient to be on supplemental oxygen.

ADDITIONAL ORDERS:

By signing below, I attest that patient is being managed by a medical provider that has examined the patient and determined a medical need for the tests ordered; no medical conditions exist that prevent the patient from completing the test.

REQUESTER'S NAME (Please print or type): _____ **M.D. D.O. PA-C FNP**

REQUESTER'S CONTACT PHONE:_____**Email:**_____

REQUESTER'S SIGNATURE _____