



SLEEP STUDY ORDER FORM

Tel: 512-452-0004

Fax: 512-452-4144



Locations in Austin, San Marcos and Texas State University - Round Rock

Patient Information

Patient Name: _____ DOB: _____ Sex: M / F
 Ordering: _____ PCP: _____ Medical record #: _____
 Address: _____ City: _____ Zip: _____
 Home: _____ Work: _____ Other: _____

All diagnostic sleep studies will automatically be run as an Out of Center Sleep Test if insurance denies reimbursement for an in-lab sleep study.

Diagnosis / CMN

- | | |
|--|--|
| <input type="checkbox"/> Do not perform an OCST if in-lab reimbursement is denied
<input type="checkbox"/> 2 Night Study (1 nPSG Diagnostic, 1 PAP Titration if AHI > 5)
<input type="checkbox"/> Split Night – ½ diagnostic, ½ titration (Per AASM standard)
<input type="checkbox"/> Full night diagnostic study – nPSG
<input type="checkbox"/> Out of Center Sleep Test - Home Sleep Test (2 Nights)
<input type="checkbox"/> Full night titration (CPAP / BiPAP)
<input type="checkbox"/> PAP Titration with a back-up rate (ASV/BiPAP ST)
<small>Requires >50% Central/Mixed Apneas to qualify for MCR</small>
<input type="checkbox"/> NPSG/MSLT – Multiple sleep latency test
<input type="checkbox"/> Other: _____
Special needs/orders: _____ | <input type="checkbox"/> G47.33 R/O / Treat OSA
<input type="checkbox"/> G47.30 Sleep apnea, unspecified
<input type="checkbox"/> G47.31 Central/Complex sleep apnea
<input type="checkbox"/> G47.10 Hypersomnia, unspecified
<input type="checkbox"/> G47.69 Sleep related movement disorder, unspecified
<input type="checkbox"/> G47.419 Narcolepsy w/o cataplexy
<input type="checkbox"/> G47.411 Narcolepsy w/ cataplexy
<input type="checkbox"/> E66.01 Morbid Obesity
<input type="checkbox"/> G47.61 Periodic Limb Movement disorder
<input type="checkbox"/> _____
<input type="checkbox"/> _____
<input type="checkbox"/> _____ |
|--|--|

Physical

History/Height: _____
 Weight: _____
 BMI: _____
 Neck size: _____ (in)
 Other: _____

Cardio/Pulmonary History

- COPD
- SOB upon awakening
- Hypertension
- Abnormal EKG
- Ischemic heart disease
- CHF
- Other: _____

Sleep History

- Snoring
- Witnessed Apnea
- Distrupted sleep
- Night sweats
- Nocturia
- Bruxism
- EDS
- Epworth _____

Neuro-Psych History

- Hypersomnia
- Restless Legs
- Leg cramps
- Morning headaches
- Impaired cognition
- Mood Disorders
- Other: _____

Interpreting Physician:

- Sleep Lab to Arrange Board Certified Sleep Specialist
 Interpreting Physician to Follow Patient for PAP Therapy
 Other: _____
(PLEASE SPECIFY INTERPRETING PHYSICIAN)

Physician Signature: _____ Date: _____
 Please print physician name: _____ NPI: _____
 Clinic location: _____ Fax: _____ Phone: _____

Insurance List for REM Sleep

- | | | | |
|------------------------|-------------------------|-------------------|-------------------|
| Aetna | Evercare | Medicaid | Texas True Choice |
| Amerigroup | Humana | Medicaid - BCBS | Tricare |
| Blue Cross Blue Shield | Medicare | PHCS | United Healthcare |
| Cigna | MediView (ARIA Network) | Superior Medicaid | |