**Infinity Sleep Solutions**
*"A better night's sleep."*
**Phone: (602) 942-3777 Fax: (602) 942-2722**

**S.T.A.R.S. Healthcare**
*"Where patients are our priority."*
**Phone: (480) 282-6500 Fax: (480) 282-6600**

# Sleep Testing Request Form

Patient Name: _____ DOB: _____
Address: _____
Gender: M / F Patient Phone #: _____ Cell: _____
Insurance Company: _____ Secondary Ins.: _____

**Please include the following with your order: Clinical Notes ▪ Insurance Info/Card(s) ▪ Signed Order**
**For your convenience Infinity Sleep Solutions/S.T.A.R.S. will obtain any prior authorization needed**

## Indications for Testing

□ Obstructive Apneas/Witnessed Breathing Pauses G47.33
□ Primary Central/Complex Sleep Apnea G47.31
□ Unspecified Sleep Apnea G47.30
□ Hypersomnia, Unspecified G47.10
□ Excessive or Abnormal Body/Limb Movements G47.61
□ Habitual Choking, Gasping, or Night sweats G47.30
□ Central/Complex Apnea G47.61
□ Excessive Daytime Sleepiness G47.10
□ Narcolepsy G47.419
□ Other _____

## Services/Tests Ordered

□ **95810 Diagnostic PSG**
□ **95810 Pediatric Diagnostic PSG (No PAP administered: ETCO2 monitored - Ages 6+)**
□ **95811/95810 Split Night PSG with Titration (Initiate PAP if Medicare AHI >15/hr or >5/hr with qualifying 2nd DX)**
*** Initial for patient to return for a titration study if split night is unable to be performed or completed _____
□ **If in-lab study is denied, proceed with Home Sleep Study (HST)**
□ **95811 CPAP/BIPAP/ASV Titration (please circle one) - Previous diagnostic study required**
□ **95805 MSLT (Daytime Study - Preceding PSG required)**
□ **95805 MWT (Maintenance Wakefulness Test)**
□ **95806 Home Sleep Study (HST)**
□ **95807 PAP Acclimation - PAP Nap (Helpful for patients having trouble acclimating to PAP)**
□ **95808 3 Lead EEG Nap Study (Ideal for patients on CPAP or dental devices, previous sleep study required)**
□ **Sleep Consultation before sleep study with a Board Certified Sleep Physician**
□ **Follow-up Sleep Consultation after sleep study with a Board Certified Sleep Physician**

**Special Instructions:**

The information contained in this form has been completed by me or my employee & reviewed by me.
All of the information provided is true and complete to the best of my knowledge.

**Physician Practice:**_____ **Physician Name/Provider:** _____
**Office Phone:** _____ **Fax:**_____
**Handwritten Signature:** _____ **Date :** ____/____/_____ **NPI:**_____

## Infinity Locations

| Phoenix | Surprise | Scottsdale | Tempe |
|---|---|---|---|
| 15640 N. 7th St., Suite. A-1 Phoenix, AZ 85022 | 12133 W. Bell Rd., Suite. 101 Surprise, AZ 85378 | 13840 N. Northsight Blvd., Suite.117 Scottsdale, AZ 85260 | 3280 S. Country Club Way, Suite. 112 Tempe, AZ 85282 |

## S.T.A.R.S. Locations

| Chandler | Sun City | Estrella |
|---|---|---|
| 2350 W. Ray Rd., Suite. L101 Chandler, AZ 85224 | 13203 N.103rd Ave., Suite. I-7 Sun City, AZ 85351 | 9305 W. Thomas Rd., Suite. 465 Phoenix, AZ 85037 |

**ACHC Accredited**