National Sleep Solutions Inc.

Sleep Specialist

SLEEP STUDY ORDER FORM

Patient's Name:_____ Date of Birth:_____Male_____Female_____

Address:_____

Phone (Home) _____(cell) _____(work)_____

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
__Other_____

_____

Services Requested:

__Comprehensive evaluation and treat of patient for suspected sleep-related disorder.
__ Polysomnography (PSG) studies
- __Diagnostic study only (1 night) : CPT 95810
- __Titration study only (1night) : CPT 95811
- __ Diagnostic study followed by titration study if certain requirements are met (2 nights) CPT 95810/95811
- __Pediatric diagnostic study (< 6 years of age): CPT 95782
- __Pediatric titration study (< 6 years of age): CPT 95783

__Home Sleep Apnea test: CPT G0399
__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, symptom duration, sleep hygiene survey) and physical examination (focused cardiopulmonary and upper airway, neck circumference, BMI) and have concerns for the presence of one or more of the above listed symptoms and suspected diagnoses. Documentation of my clinical evaluation is included with this request.

Physician's Signature _____ NPI:_____

Printed Name:_____Date:_____

Address:_____

Phone :_____Fax: _____

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

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