Sleep Study Order Form

365 Warner Milne Rd. Suite 209 | Oregon City, OR 97045

Phone: (503) 495-6200 | Fax: (503) 495-6208

Patient Information	
Name:	Birthdate:
Phone:	Email:
Address:	
Height (inches):	Weight (lbs.):

Procedure
☐ Polysomnography Study Only (95810)
☐ Polysomnography Study w/CPAP Titration per Protocol / Split Night (95810 / 95811)
☐ All Night PAP Titration on: ☐ CPAP ☐ BiPAP ☐ ASV (95811)
☐ Home Sleep Apnea Test, Type III, Unattended (95800, 95806)
☐ Other:

Sleep Symptoms / Clinical Indications (check all that apply)		
☐ Epworth Sleepiness Scale ≥10	☐ Witnessed Apneas	☐ Daytime Fatigue
☐ Choking / Gasping	☐ Sleep Fragmentation	☐ Habitual snoring
☐ Excessive Daytime Sleepiness	☐ Morning Headaches	☐ Other:

Complete this section if this is for <u>REPEAT TESTING</u>	
Prior Diagnosis of apnea? ☐ Yes ☐ No	If yes, test date:
Type of Treatment: ☐ Surgery ☐ Oral Appliance ☐ PAP ☐ Other:	
☐ Weight gain / loss > 10%	☐ Evaluate efficacy
☐ Evaluate need to continue therapy	☐ Previously inconclusive HSAT

Ordering Provider	
Name:	NPI:
Phone:	Fax:
Address:	
Signature:	Date:

Letter of Medical Necessity: I, the undersigned, certify that the above prescribed service is medically necessary as part of my medical treatment for this patient. It is my opinion that the study ordered on this form is reasonable and necessary for accepted standards of medical practice and treatment of this patient's condition.