DURANT SLEEP DIAGNOSTICS

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SLEEP LAB ORDER FORM

PATIENT NAME:_____ **DOB:**_____

ADDRESS:_____

PREFERRED PHONE:_____**EMAIL:**_____

Diagnostic Orders

_____ Home Sleep Test (CPT 95800) True Sleep Time, True Central Detection (One Time Use / Disposable Unit)

_____ Evaluate and Treat (CPT 95810 & 95811) Polysomnogram with 2nd night CPAP Titration if indicated

_____ Polysomnogram (PSG) (CPT 95810) 1st Night Diagnostic Study for Evaluation Only

_____ CPAP/BIPAP Titration (CPT 95811) 2nd Night Titration following Diagnostic Study w/ dx of OSA

_____ Follow-Up CPAP Titration (CPT 95811) for patient currently using CPAP therapy

_____ Split Night Study (CPT 95811) Initial Diagnostic period followed by CPAP titration for RDI>40

Physician Signature & Certification

I, the undersigned, certify that I am the patient's treating physician and that the information contained on this form is based on a face- to-face office visit. The ordered testing is medically necessary based on the patient exhibiting the symptoms notated.

SIGNATURE:_____

DATE: _____

NPI:_____

PHONE: _____

FAX:_____

(Stamped dates/signatures not valid. Must be signed by Physician/PA/NP)

Pt Height:_____ (in) **Pt Weight:**_____ (lbs)

Diagnosis Codes

_____ **G47.33** OSA witnessed breathing pauses during sleep

_____ **G47.10** Excessive Daytime Sleepiness/ Hypersomnia

_____ **G47.00** Insomnia of unknown etiology

_____ **G47.419** Narcolepsy/Daytime sleepiness attacks

_____ **G47.30** Insomnia with apnea

_____ **G47.61** Periodic Limb Movements during sleep

_____ **G25.81** Restless Legs while falling asleep

_____ **R06.83*** Loud or disruptive snoring

_____ **R40.0*** Somnolence or Drowsiness

_____ **R53.83*** Fatigue or Malaise

_____ **E66.9*** Obesity

_____ **E66.01*** Morbid Obesity

_____ **G47.26*** Shift Work

Must include a primary diagnosis

FAX or EMAIL ORDER with:

1. **Patient Demographics and Insurance Info.**
2. **Physician's Face to Face Notes**

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***Both are HIPAA Compliant ***