



Please Fax
completed order form to
(346) 443-2398

Patient Name: _____ DOB: _____

PLEASE ATTACH: ☐ DEMOGRAPHIC SHEET ☐ HISTORY & PHYSICAL

Study Ordered:

- ☐ **Full Sleep Evaluation with Sleep Education**
- ☐ **First Night Sleep Study**
NPSG Diagnostic - CPT: 95810 (In-Lab)
_____ Full Seizure Montage _____ RBD Montage
- ☐ **Second Night Sleep Study** CPAP/BiPAP Titration - CPT: 95811 (In-Lab)
- ☐ **Home Sleep Test up to Three Nights**- CPT: 95800, 95806, G0398, G0399, G0400
- ☐ **NPSG w/MSLT**- Multiple Sleep Latency Test- CPT: 95805 (In-Lab)
- ☐ **NPSG w/MWT**- Maintenance of Wakefulness Test- CPT: 95805 (In-Lab)
- ☐ **PAP NAP** (Daytime Abbreviated Sleep Test) - CPT: 95807 (In-Lab)
- ☐ **Other Testing:** _____

Please Include:

Height: _____ Weight: _____

BMI: _____

Neck Circumference: _____

Epworth Score: _____

Diagnosis:

- ☐ Obstructive Sleep Apnea
☐ Insomnia
☐ Narcolepsy
☐ Excessive Daytime Sleepiness
☐ REM Behavior Disorder
☐ Periodic Limb Movement Disorder
☐ Involuntary Movements
☐ Restless Legs

Comorbid Medical Conditions:

- ☐ Cognitive Impairment
☐ Neuromuscular Disorder
☐ Stroke/TIA
☐ Seizure Disorder
☐ Epilepsy
☐ Altered Mental Status
☐ Optic Neuropathy
☐ Fibromyalgia

- ☐ COPD/Asthma
☐ Hypertension
☐ Congestive Heart Failure
☐ Heart Disease
☐ Atrial Fibrillation
☐ Morbid Obesity
☐ Diabetes
☐ Other: _____

Physician Signature

Date

Physician Address

City

State

Zip

Physician Phone ()

Physician Fax ()

Faxed By (employee)

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