Simply Sleep

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)**