Sleep Study Prescription Form

Patient Name:_____ Height_____ Weight _____

Phone # _____ DOB _____

Preliminary Diagnosis**: OSA G47.33** Date/Time of Appointment: _____ / _____

Insurance Pre-certification/Pre-Authorization: _____

Requesting Physician:_____

Insurance: _____

Type of Study Requested (PLEASE CHECK ONE BOX):

□ Diagnostic PSG (CPT 95810) □ CPAP/BiLevel Titration (CPT 95811)

□ Split Night Study (CPT 95811) □ Home Sleep Study (HST) (CPT 95806)

□ Multiple Sleep Latency Test (MSLT) (CPT 95805) (PSG performed previous night)

□ Maintenance of Wakefulness Test (MWT) (CPT 95805)

□ CPAP Ventination, Initiation and Management (PAP Nap) (CPT 94660)

□ Other: _____

□ **Clinical Suspicion of Sleep Apnea?: (check if any of the following apply)**

□ Snoring
□ Epworth Sleepiness Scale ≥ 10
□ Daytime Sleepiness
□ Witnessed Apneas
□ ≥ 3 "Yes" on STOP Bang Questionnaire
□ Other _____

Medical History: (check below for all that apply)

□ Recent history of Pressure Ulcers
□ Skin sensitivity
□ Moderate to severe pulmonary disease (with pO2 less than 60 or pCO2 greater than 45)
□ Neuromuscular disease
□ Stroke
□ Epilepsy
□ Congestive heart failure
□ Super obesity (BMI greater than 45)
□ Periodic limb movement disorder
□ Parasomnias
□ Narcolepsy
□ Central sleep apnea or complex sleep apnea
□ Hypertension
□ Diabetes
□ Atrial Fibrillation
□ Other __

Special Attention for Sleep Technicians/Technologists: (check all that apply)

□ Mask desensitization with **Circadiance SleepWeaver** interface
□ Interface _____
□ Chin strap
□ Patient needs 1:1 tech ratio
□ Supplemental O2 _____l/min
□ Mobility issues
□ Other _____

Physician Signature: _____
Copies to: _____

FAX Prescription Form to:_____
Include with Fax Patient Demographic Profile & H&P or Office Notes