MASSACHUSETTS EYE AND EAR
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Sleep Testing oneForm Request
please fax completed form with most recent office notes to: 617-796-9099
For questions, please call: 617-796-7766

DEMOGRAPHIC INFORMATION

Patient Name: _____ DOB: _____ English Proficient? □ Yes □ No

Patient Phone Numbers: Mobile #: _____ Home#: _____ Alternate #: _____

Insurance Provider: _____ Insurance ID #: _____

Has patient had previous testing? □ Yes *(Study report must be submitted if completed at another facility)* □ No/Unknown
If yes, please specify reason for re-testing: _____

SLEEP STUDY REQUESTED

☐ **Polysomnography – PSG (95810):** Attended 18-channel diagnostic testing. CPAP will not be initiated.

☐ **Split Night Study (95811):** Attended 18-channel diagnostic testing including CPAP initiation & titration. If titration criteria met with less than three hours testing remaining, a new order for an all-night PAP titration study will be required. Refer to interpretation report.

☐ **PAP Titration* (95811**): Titrate positive airway pressure to optimal pressure level. **OSA must be previously documented by a PSG.*

Date of PSG:_____

□ CPAP □ Bi-level PAP* □ ASV* (for previously diagnosed complex and central sleep apnea)

☐ **Home Sleep Apnea Test – HSAT (G3099/95806)** – Unattended Type 3 diagnostic testing. Recommended ONLY for patients with high likelihood of Obstructive Sleep Apnea (OSA). Provider: Neurocare, Inc. (TIN: 043032581)

If the in-lab study is not approved and a Home Sleep Test is offered, I authorize the HST as a substitution unless "NO" is selected: □ **NO**

SPECIAL NEEDS/ASSISTANCE *(If applicable, please specify)*

INDICATION *(suspected sleep disorder)*

☐ Obstructive Sleep Apnea (G47.33)
☐ Central Sleep Apnea (G47.31)
☐ Narcolepsy (G47.419)
☐ REM Behavior Disorder (G47.52)
☐ Periodic Limb Movements (G47.61)
☐ Other:

PATIENT COMPLAINTS *(select at least one)*

☐ Excessive daytime sleepiness
☐ Disruptive snoring
☐ Frequent arousals/disturbed or restless sleep
☐ Not refreshed or rested after sleeping

SYMPTOMS (*select at least two)*

☐ Witnessed apneas
☐ Waking up gasping/choking
☐ Enlarged tonsils/physiological abnormalities
☐ Leg/arm jerking
☐ Bruxism/teeth grinding during sleep
☐ Nocturia
☐ Decreased libido
☐ Hypertension
☐ Irritability
☐ Decreased concentration
☐ Memory Loss
☐ Other:

Duration of symptoms:
□ **< 2 months** □ **> 6 months**
□ **> 2 months** □ **> 1 year**

DOCUMENTED COMORBIDITIES & MEDICAL HISTORY: REQUIRED FOR LAB STUDIES ONLY

☐ Critical illness or physical impairments preventing use of portable HST device
☐ Moderate to severe Congestive Heart Failure
☐ History of Myocardial infarction (s/p 3 mo.)
☐ History of stroke (Date: _____)
☐ Neuromuscular weakness affecting respiratory function or impairing activity (please specify: _____)
☐ Moderate to severe pulmonary disease
☐ Patient prescribed opiates: _____
☐ Polycythemia
☐ Other:

I acknowledge that the clinical information submitted to support this request is accurate and specific to this patient, and all information has been provided. I authorize submission of this information for precertification on my behalf.

Ordering Provider Signature: _____ Date: _____

Print Name: _____ NPI: _____