Parkland Medical Center

REQUEST FOR SLEEP TESTING SERVICES

FAX to 1-603-421-2293 with most recent visit notes

603-421-2458 ***Scheduling***

Please choose the interpreting physician for the patient's study:
☐ J. Rind, MD ☐ G. Smull, MD ☐ U. Luchanok, MD ☐ M.Pohlman, MD ☐ No Preference

Patient Name _____ D.O.B. _____/_____/_____ English Proficient: YES NO

Patient Phone Numbers: (_____)_____ Home (_____) _____ Alternate

Height _____ Weight _____ BMI___

☐ **TUFTS***	☐ **AETNA***	☐ **BCBS***	☐ Medicaid
☐ **HPHC***	☐ **UNITED***	☐ BCBS PPO/Federal	☐ Masshealth
☐ **CIGNA***	☐ **TRICARE***	☐ MEDICARE	☐ Other:

*Precert Required

SERVICES REQUESTED

☐ **SLEEP SPECIALIST CONSULT:** Consultation and treatment management.
Sleep Specialist will order and precertify sleep testing, CPAP order and set-up, CPAP compliance monitoring and re-certification if applicable

DIAGNOSTIC TESTING

☐ **Split Night Study (PSG and titration in one night) with CPAP Titration (95811)**

☐ **Diagnostic Polysomnography Only (95810)**

☐ **All Night Titration (95811)** _____CPAP _____ BILevel PAP _____Adapt Servo Ventilation
Previous Study Date: _____

☐ Study is repeat titration for insufficient response to compliant PAP therapy despite mask refitting and education

☐ **Home Sleep Test (95806)**

INDICATIONS FOR STUDY

☐ OSA (327.23)
☐ Central Sleep Apnea (327.41)
☐ Unspecified Sleep Apnea Symptoms (780.57)*
☐ Other: _____

☐ REM Behavior Disorder (327.42)
☐ Periodic Leg Movement Disorder/Restless Legs Syndrome (327.51)
☐ Parasomnias (327.44)
☐ Narcolepsy (347.00)

SIGNS/SYMPTOMS and MEDICAL HISTORY TO SUPPORT MEDICAL NECESSITY

☐ Witnessed Apneas
☐ Gasping/Choking Upon Awakening
☐ Excessive Daytime Sleepiness
☐ Non-restorative sleep
☐ Insomnia / Fragmented Sleep
☐ Snoring
☐ Overweight
☐ Weight Gain
☐ Weight Loss

☐ Leg Cramps, Movement or Jerks
☐ Sleep Walking or Talking
☐ Nightmares or Night Terrors
☐ Bruxism / Teeth Grinding
☐ Morning Headaches
☐ Decreased concentration/memory loss
☐ **Other Symptoms/Complaints:**

☐ Heart Disease
☐ Atrial Fibrillation
☐ COPD
☐ Hypertension
☐ CHF
☐ Stroke
☐ Seizures
☐ Neurodegenerative Disorder:

☐ Anxiety
☐ Impaired Cognition
☐ Mood Disorders
☐ Sinusitis / Rhinitis
☐ Diabetes
☐ Supplemental 02 Req'd
☐ **Other:**

SPECIAL NEEDS / ASSISTANCE REQUIRED

☐ Functional/Developmental Disability: _____ ☐ Medication Allergy: _____ ☐ Other: _____

Signature:_____ **(REQUIRED)** **Date**: _____/_____/_____ **(REQUIRED)**
(Must be enrolled with Medicare to order services for Medicare patients)

Physician (print name):_____**(REQUIRED)** **NPI:** _____