



**DEMOGRAPHIC INFORMATION**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ English Proficient? ☐ Yes ☐ No  
 Patient Phone Numbers: Mobile #: \_\_\_\_\_ Home#: \_\_\_\_\_ Alternate #: \_\_\_\_\_  
 Insurance Provider: \_\_\_\_\_ Insurance ID #: \_\_\_\_\_

**SLEEP STUDY REQUESTED**

- ☐ **Polysomnography (95810):** All night attended diagnostic sleep study (PSG) to evaluate for all sleep disorders.
- ☐ **Split Night (95811):** Attended 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:** \_\_\_\_\_
- ☐ **Home Sleep Apnea Test (G0399/95806):** (HSAT) 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 (please specify)**

- ☐ Supplemental Oxygen (if selected, HSAT cannot be performed)

**INDICATION (suspected sleep disorder)**

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

**PATIENT COMPLAINTS (select at least one)**

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

**SYMPTOMS (select at least two)**

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

**\*Duration of Symptoms:**

- ☐ < 2 months ☐ > 6 months  
☐ > 2 months ☐ > 1 year

**DOCUMENTED COMORBIDITIES & MEDICAL HISTORY**

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