

**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** Please choose the Interpreting Physician for your patient’s study

* **G Stanton, MD P Aghassi, MD M Mehta, MD**

□

□

* **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)

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

* Narcolepsy (G47.419)
* REM Behavior Disorder (G47.52)
* Periodic Limb Movements (G47.61)
* Other:
* 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

**Duration of symptoms:**

**□ < 2 months □ > 6 months**

**□ > 2 months □ > 1 year**

* Decreased concentration
* Memory Loss
* Other:

Other:

□

□

□

Patient prescribed opiates:

Polycythemia

□

□

function or impairing activity (please specify:

)

□ Moderate to severe pulmonary disease

History of Myocardial infarction (s/p 3 mo.)

History of stroke (Date: )

Neuromuscular weakness affecting respiratory

□

□

Critical illness or physical impairments preventing use of portable HST device

Moderate to severe Congestive Heart Failure

□

**DOCUMENTED COMORBIDITIES & MEDICAL HISTORY: REQUIRED FOR LAB STUDIES ONLY**

## 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: