

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)

- | | | |
|---|---|---|
| <input type="checkbox"/> Obstructive Sleep Apnea (G47.33) | <input type="checkbox"/> Narcolepsy (G47.419) | <input type="checkbox"/> Periodic Limb Movements (G47.61) |
| <input type="checkbox"/> Central Sleep Apnea (G47.31) | <input type="checkbox"/> REM Behavior Disorder (G47.52) | <input type="checkbox"/> Other: |

PATIENT COMPLAINTS (select at least one)

- | | |
|---|--|
| <input type="checkbox"/> Excessive daytime sleepiness | <input type="checkbox"/> Frequent arousals/disturbed or restless sleep |
| <input type="checkbox"/> Disruptive snoring | <input type="checkbox"/> Not refreshed or rested after sleeping |

SYMPTOMS (select at least two)

- | | | |
|---|--|--|
| <input type="checkbox"/> Witnessed apneas | <input type="checkbox"/> Bruxism/teeth grinding during sleep | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Waking up gasping/choking | <input type="checkbox"/> Nocturia | <input type="checkbox"/> Decreased concentration |
| <input type="checkbox"/> Enlarged tonsils/physiological abnormalities | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Memory Loss |
| <input type="checkbox"/> Leg/arm jerking | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Other: |

Duration of symptoms:
☐ < 2 months ☐ > 6 months
☐ > 2 months ☐ > 1 year

DOCUMENTED COMORBIDITIES & MEDICAL HISTORY: REQUIRED FOR LAB STUDIES ONLY

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