SSM HEALTH | SLEEP SERVICES at DEPAUL HOSPITAL
Please complete entire order sheet and fax to (314) 770-0849

SSMHealth
Sleep Services

Insurance Requirements:
Complete the entire order sheet.
Attach a detailed face-to-face note stating the reason (medical necessity) for the sleep test.
Attach a completed Epworth Sleepiness Scale.
Patient BMI: _____ Neck Circumference: _____ inches

Patient Name: _____ DOB: _____/_____/_____
Social Security #: _____ Employer: _____
Address: _____
Home #: _____ Cell #: _____
Patient Insurance: _____ Insured Name: _____
ID #: _____ Group #: _____
Primary Care Physician: _____ Phone: _____ Fax: _____

Circle Patient Symptoms: Disruptive snoring Excessive daytime sleepiness Nocturia
Disturbed or restless sleep Witnessed apnea events Choking in sleep Gasping in sleep Fatigue

_____ **Baseline Polysomnography** (CPT 95810) – Complete **Split Night** if patient meets protocol OR **Home Sleep Test** if mandated by patient insurance (CPT 95806)

Circle diagnosis code: (1) Central sleep apnea G47.37 (2) Excessive daytime sleepiness G47.10 (3) Hypersomnia with sleep apnea, unspecified G47.10 w/G47.30 (4) Narcolepsy with cataplexy G47.411 (5) Narcolepsy w/o cataplexy G47.419 (6) Obstructive sleep apnea G47.33 (7) Periodic limb movement G47.61 (8) Primary sleep apnea G47.31 (9) Sleep related hypoventilation G47.36 (10) Unspecified sleep disturbance G47.9 Other: _____

Required to determine the appropriate test:
Has patient been diagnosed with chronic pulmonary disease? Yes No
Has patient been diagnosed with neuromuscular or neurodegenerative disease? Yes No
Has patient been diagnosed with congestive heart failure? Yes No
Is there a suspicion of periodic limb disorder (restless leg syndrome), parasomnia, narcolepsy, or central/complex sleep apnea? Yes No
Is patient on continuous oxygen therapy which cannot be removed for sleep testing? Yes No
Does patient exhibit cognitive impairment or lack the mobility/dexterity to use home sleep equipment? Yes No

_____ **CPAP** (CPT 95811) _____ **Bipap Titration** (CPT 95811) _____ **ASV** (CPT 95811)
_____ **MSLT** (CPT 95805) – Must be approved by Medical Director

Circle diagnosis code: (1) Hypersomnia with sleep apnea, unspecified G47.10 w/G47.30
(2) Obstructive sleep apnea G47.37 (3) Primary sleep apnea G47.31
Other: _____

Ordering Physician (Print name): _____

Physician Signature: _____ Date: _____

Phone: _____ Fax: _____

We will notify your office of the appointment date and send all test preparation information directly to the patient. If you have any questions, please contact us at (314) 770-0809.

Please fax completed documents to (314) 770-0849
THANK YOU – WE APPRECIATE THE REFERRAL

Patient ID Label