Sleep Diagnostic Services – Columbia, MO
Please complete entire order sheet and fax to (800) 317-5343.

SLEEP DIAGNOSTIC SERVICES
Sleep. Health. Life.

Insurance Requirements: .
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

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, 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

YES ___ NO ___ Patient or a caregiver may self-administer home medication while at the sleep lab.

_______ **Baseline Polysomnography** (CPT 95810) – **Possible Split Night if patient meets protocol** then a CPAP (CPT 95811) will be performed 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 (11) Nocturnal Hypoxemia G47.34. Other: ____

________ **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 G47.33 (3) Primary sleep apnea G47.31
Other: ____

Consult Information: If you would like a pre-consult, post-consult or both please indicate that below.
____ I would like a pre-consult with a Board Certified Sleep Specialist (specialist will determine type of sleep study)
____ I would like a post-consult with a Board Certified Sleep Specialist (recommended for Medicare patients). This includes CPAP equipment set-up, CPAP compliance check, and continued follow-up as required.

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 (800) 317-3600.

THANK YOU – WE APPRECIATE THE REFERRAL