SSM HEALTH | SLEEP SERVICES at DEPAUL HOSPITAL

Please complete entire order sheet and fax to (314) 770-0849.

SSMHealth Sleep Services

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 Appropriate Test Has patient been diagnosed with: (1) Chronic pulmonary disease? Yes No (2) Neuromuscular/neurodegenerative disease? Yes No (3) Congestive heart failure? Yes No (4) Is there a suspicion of periodic limb disorder, parasomnia, narcolepsy, or central/complex sleep apnea? Yes No (5) Is patient on continuous oxygen therapy which cannot be removed for sleep testing? Yes No (6) 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)_____; Split Night with CPAP (CPT 95811) if patient meets protocol_____; Home Sleep Test (CPT 95806) if mandated by patient insurance_____.

Circle Diagnosis Code(s): (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 without 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 (12) Other:_____

CPAP (CPT 95811)_____; BIPAP Titration (CPT 95811)_____; ASV (CPT 95811)_____;
MSLT (CPT 95805) *Must be approved by Sleep Center Medical Director*_____.

Circle Diagnosis Code(s): (1) Hypersomnia with sleep apnea, unspecified G47.10 w/G47.30 (2) Obstructive sleep apnea G47.33 (3) Primary sleep apnea G47.31 (4) Other: _____

Consult Information: If you would like a pre-consult, post-consult or both please indicate 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.

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

Ordering Physician (Print name): _____

Physician Signature: _____ Date: _____

Phone: _____ Fax: _____

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

THANK YOU – WE APPRECIATE THE REFERRAL

Patient ID Label
Sleep Lab use only