EMORY HEALTHCARE

EMORY SLEEP CENTER

Medical Necessity for Sleep Study

Affix sticker here

FAX to 404.712.8145

To ensure documentation of medical necessity for the sleep study ordered for your patient, please complete the Letter of Medical Necessity below or provide a letter of medical necessity/clinical notes that substantiates signs and symptoms suggesting that the patient may have a sleep related disorder as indicated on the Request for Services.

Please call 404-712-7533 if you require assistance

Supervised PSG performed in a sleep laboratory is medically necessary for my patient ___________________________________,

DOB: ______________ seen in my office ________/_______/_______ due to the following:

Past Medical History (check all that apply)

- ☐ Sleep apnea
- ☐ Hypertension
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Stroke
- ☐ Atrial Fibrillation
- ☐ Pulmonary Hypertension
- ☐ Nocturnal oxygen desaturation with unexplained right heart failure, polycythemia, or cardiac arrhythmias during sleep
- ☐ Obesity BMI>30Kg/m2
- ☐ Anxiety/Depression/Mood Disorder
- ☐ Diabetes
- ☐ Craniofacial or soft tissue abnormality
- ☐ Narcolepsy
- ☐ Restless Legs Syndrome
- ☐ Insomnia
- ☐ Other:

Symptoms (check all that apply)

- ☐ Witness apneas during sleep
- ☐ Epworth >10 (Score:)
- ☐ STOP BANG >3
- ☐ Awakens with choking or gasping sensation
- ☐ persistent snoring
- ☐ Daytime sleepiness
- ☐ MVC or close call from falling asleep while driving
- ☐ Tired in morning after sleeping at night
- ☐ Frequent nocturnal awakenings to urinate
- ☐ Hynagogic/hypnapompic hallucinations
- ☐ Sleep paralysis
- ☐ Cataplexy
- ☐ Violent or injurious behavior during sleep
- ☐ Periodic movements of limbs during sleep
- ☐ Awakens with headache
- ☐ Other:

Pertinent Physical Exam Findings (Height, Weight, BMI, BP, Upper airway, Lung/Cardiac exam):

Other pertinent history:

____ _________________

MD Signature **Date**

____

Print Name

2/1/11