

REQUEST FOR SLEEP CENTER SERVICES

FAX to 404.712.8145

H&P, Office Notes or Medical Necessity Form with supporting medical necessity for testing is required to schedule services

Complete or affix sticker

Patient Name _____

D.O.B. ____/____/____

Height _____ Wt _____ lbs.

Patient Phone Numbers: (_____) _____ Home

Sleep Clinic Appointment (Initial visit with sleep specialist)

Sleep study followed by Sleep Clinic appointment

Sleep Specialist Review:
Date:
Comments:

Emory Midtown (please check if sleep clinic appointment preferred at MOT)

Diagnostic testing performed as **an all night diagnostic sleep study** followed by clinic visit with sleep practitioner to inform patient of results and manage care, including PAP treatment, if indicated.. **(Split Night study will be performed if required by payor criteria or lab emergency protocol).**

Sleep Testing Only- as ordered below (Patient will not be seen in sleep clinic. Ordering physician to inform patient of results and manage care)

Testing Options:

Sleep Study All night diagnostic sleep study. CPAP will be applied if severe apnea is present.

Split Night Sleep Study A diagnostic sleep study followed by CPAP titration if appropriate clinical criteria are met (ordering physician must discuss CPAP with patient prior to study) If criteria are met too late to initiate treatment, patient will be scheduled for a subsequent CPAP titration study

CPAP Titration Study Titrate positive airway pressure to optimal pressure level.

Other Study, please specify _____

REASON FOR STUDY:

- | | | |
|---|--|--|
| <input type="checkbox"/> Obstructive Sleep Apnea (327.23) | <input type="checkbox"/> Central Sleep Apnea (327.21) | <input type="checkbox"/> Restless Legs Syndrome (333.94) |
| <input type="checkbox"/> Periodic Limb Movement Disorder (327.51) | <input type="checkbox"/> Hypoventilation Syndromes (278.03) | <input type="checkbox"/> Narcolepsy (347.00) |
| <input type="checkbox"/> Unspecified Sleep Apnea (780.57) | <input type="checkbox"/> Parasomnias (327.40) | <input type="checkbox"/> Hypersomnia (780.54) |
| <input type="checkbox"/> Weight Loss/Gain to ascertain optimal PAP (327.23) | <input type="checkbox"/> Insufficient response to PAP (327.23) | <input type="checkbox"/> Insomnia (780.52) |
| <input type="checkbox"/> Ascertain efficacy of surgery for OSA (327.23) | <input type="checkbox"/> Ascertain efficacy of oral appliance (327.23) | <input type="checkbox"/> Other: |

SPECIAL NEEDS AND INSTRUCTIONS:

- | | |
|--|--|
| <input type="checkbox"/> Study should be performed on oxygen; liter flow: _____ | <input type="checkbox"/> Patient uses walker, wheelchair, requires assistance for mobility |
| <input type="checkbox"/> Patient should wear dental appliance for study | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Allergies: <input type="checkbox"/> Tape <input type="checkbox"/> Latex <input type="checkbox"/> Talc | <input type="checkbox"/> Interpreter required: |
| <input type="checkbox"/> Medication Adverse Reaction: _____ | <input type="checkbox"/> Significant cognitive impairment: |

Requesting Physician: _____ **Date:** __/__/__ **FAX:** _____

Signature: _____ **Phone:** _____

Office Use: