Patient Information (Required for Scheduling)

Patient Name:_____ DOB: _____ Sex: ❑ M ❑ F SS#: XXX-XX- _____
First & Last Name

Patient's Address: _____ _____ _____ _____
Street City State Zip Code

Home Phone#: _____ Mobile Phone #: _____ Email Address: _____

Primary Insurance: _____ Policy #: _____ Group #:_____ Phone #:_____
Plan & Product

Secondary Insurance: _____ Policy #: _____ Group #:_____ Phone #:_____
Plan & Product

Order Information - Sleep Disorder Center

Presenting Symptoms:

❑ Loud snoring ❑ Non-restorative sleep Other (please specify): _____
❑ Observed apnea ❑ Limb restlessness/jerks
❑ Excessive daytime sleepiness ❑ Sleep paralysis or cataplexy
❑ Difficulty initiating sleep ❑ Early AM awakening
❑ Difficulty maintaining sleep ❑ Hypnogogic/Hypnapompic hallucinations

Risk Factors: ❑ Hypertension ❑ Stroke ❑ Myocardial Infarction ❑ CHF

Current Medications (please list or attach):_____

Allergies (please list) _____

Physician exam (please attach clinic note and patient demographics)

_____ Height _____ Weight _____ BMI _____ Obesity _____ Epworth

Suspected Diagnoses (check at least one):

❑ Obstructive Sleep Apnea (327.23)
❑ Complex/Central Sleep Apnea (327.21)
❑ Narcolepsy (347)
❑ Parasomnia (please check) ❑ Limb movements (327.51) ❑ Sleepwalking (307.46) ❑ Seizure (345.10)
❑ Insomnia (780.52)
❑ Other (please specify): _____
ICD-CM Diagnosis Codes for each diagnosis: _____

Test(s) Requested:

❑ Polysomnography (95810)
❑ C/Bi/ASV Titration (95811)
❑ Split night (95811)
❑ Home Sleep Test (95806)
❑ MWT (95805)

Special requirements:

❑ Video
❑ Additional EEG
❑ May use O_2 up to 5 lpm to maintain greater than 90% saturation
❑ Three Night Premium Home Testing Service
❑ MSLT (95805)
❑ Begin O_2 pre study
❑ If SAO_2 is less than 85%

Follow-up Options: (A copy of all results will be sent to the referring physician)

❑ Perform the CPAP/Bi-Level titration if polysomnogram demonstrates sleep apnea
❑ Referring Doctor will counsel patient and order further studies or treatment as needed
❑ Consult the interpreting physician for patient's management
❑ Sleep Center to arrange for CPAP/BiPAP therapy

Referring Physician Information

Physician Name (first & last): _____ NPI#:_____ GA License#: _____

Physician Address: _____ Phone#: _____ Fax #:_____

I herby certify that the services in the above order form are medically necessary.

Physician Signature: _____ **Date:** _____ **Time:** _____

EMORY HEALTHCARE

PS-1058

FAX Orders to: 404.501.7088
Phone: 404.501.5927

SLEEP DISORDER CENTER ORDER FORM

DMC FORM # PS-1058 (10/31/14)