

SLEEP STUDY ORDER FORM

Patient Information

Name: _____ DOB: _____
Last First MI

Phone (home): _____ Phone (cell): _____

PLEASE ATTACH:

- ✓ **Demographic sheet**
- ✓ **Recent clinical note**
to include history & physical exam
- ✓ **Insurance information**

Ordering Information for Polysomnogram

Please indicated the type of polysomnogram (PSG) needed:

- Diagnostic PSG**, 6 years+ (95810)
- Diagnostic PSG**, 3 months to 5 years (95782)
- PSG + PAP titration**, 6 years+ (95811)
- PSG + PAP titration**, 3 months to 5 years (95783)

Please indicate any/all symptoms present:

- Snoring
- Apnea
- Mouth breathing
- Daytime sleepiness
- Frequent awakenings
- Enlarged tonsils
- Restless sleep
- Other _____

Suspected Diagnoses:

- Sleep Apnea
- Obstructive Sleep apnea
- Central Sleep Apnea
- Narcolepsy
- Hypoxemia
- Hypoventilation
- Parasomnia
- PLMD
- Other: _____

Referring Provider: _____ Phone _____ Fax _____

Ordering Provider Signature _____ Date _____

Provider Printed Name _____ Practice Name _____

Results will be sent to the ordering provider to review with your patient.

----- Area Below For Sleep Laboratory Use Only -----

I reviewed the sleep study order History and Physical the sleep study is indicated per criteria previous sleep study results

Comments: _____

Signature: _____ Date: _____