



PLEASE FAX TO: Phoenix 480-603-0620
Tucson 520-575-7281

SLEEP STUDY ORDER FORM

Date: _____
Name: _____ DOB: ____/____/____
Address: _____ Home Phone: (____) ____-____
City: _____ Zip: _____ Wk/Mobile Phone: (____) ____-____
Gender: M F Email Address: _____
Insurance: _____ ID: _____ Group: _____
Insurance: _____ ID: _____ Group: _____

Orders/Requests

CONSULTATIONS

- Consultation with Sleep Specialist: { } Pre-Study { } Post Study/Follow-Up
- Daytime Mask Fitting/CPAP Clinic: Indicated for patients with mask intolerance.

SLEEP STUDIES

- Diagnostic Polysomnogram* (98510): Do **not** initiate CPAP.
- Pediatric Polysomnogram (95810): Ages 3-12; EtCO2
- Split Night PSG* (95810-95811): Initiate PAP if Medicare/AASM AHI ≥ 15; AHI 5-14 with co-morbidities
- Titration Study (95811): Previous DX study required.
- BiPAP Titration (95811): For treatment of: { } Neuromuscular Disease; { } COPD; { } OSA
- AutoSV Titration Study (95811): Requires the diagnosis of Complex Sleep Apnea
- Multiple Sleep Latency Test (MSLT) (95810/95811+95805): Daytime study, preceding PSG is *required*.
- Maintenance Wakefulness Test (MWT) (95805): Daytime study
- Home Sleep Test (HST) (95806): Type III study, Apnea Link +

* In the event that the above named patient cannot participate in an in-lab attended study as ordered, a diagnostic home study or screening may be suggested, either in lieu of a laboratory study or as a screening device when necessary per requirements of the patient's insurance carrier. In such circumstances, the referring physician's office will be contacted prior to any action for the appropriate order or other necessary direction.

Initial Complaints/Reasons for Sleep Study

Primary Diagnosis	Supporting Diagnosis
<input type="checkbox"/> 327.23 Obstructive Sleep Apnea <input type="checkbox"/> 780.54 Excessive Daytime Sleepiness/Hypersomnia <input type="checkbox"/> 780.51 Insomnia with Sleep Apnea <input type="checkbox"/> 780.53 Hypersomnia with Sleep Apnea <input type="checkbox"/> 327.24 Idiopathic Non Hypoventilation/Hypoxemia <input type="checkbox"/> 780.57 Unspecified Sleep Apnea <input type="checkbox"/> 780.09 Alteration of Consciousness <input type="checkbox"/> 347.00 Narcolepsy, w/o Cataplexy <input type="checkbox"/> 347.01 Narcolepsy with Cataplexy <input type="checkbox"/> 327.51 Periodic Limb Movement Disorder	<input type="checkbox"/> Snoring <input type="checkbox"/> Hypertension <input type="checkbox"/> Cardiovascular Disease <input type="checkbox"/> Abnormal Sleep Behaviors <input type="checkbox"/> Obesity or Significant Weight Gain/Loss <input type="checkbox"/> Epiepsy and Recurrent Seizures *Must include a PRIMARY DX _____ Epworth Sleepiness Scale (ESS) Is patient willing to us CPAP, if prescribed? Yes No

To expedite scheduling, please fax this completed form along with:

- Clinical Notes/History
- Insurance Card(s)
- Signed Referral/Order

I authorize CSS to perform services on the above patient according to the clinical protocols approved by the Medical Director.

Physician Name: _____

Physician Signature: _____ Contact: _____

Office Phone: _____ Fax: _____

Phone: Phoenix
480-603-0615

Thank You For Your Referral !
www.comprehensivesleep.com

Phone: Tucson
520-575-6400