



Sleep Management Services
Bradley County Medical Center

1-877-989-9919 or 501-224-5200 FAX: 501-224-5208

PHYSICIAN SLEEP EVALUATION AND ORDER

ATTACH: PATIENT DEMOGRAPHIC & INSURANCE INFORMATION, CURRENT H&P AND LAST TWO OFFICE VISIT NOTES

Patient Name: \_\_\_\_\_ SSN: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_ HT: \_\_\_\_\_ WT: \_\_\_\_\_ PHONE: \_\_\_\_\_

HISTORY OF PRESENT ILLNESS / SUPPORTING DX AND SYMPTOMS:

Table with 3 columns of symptoms: Loud or Disruptive Snoring, Excessive Daytime Sleepiness, Sleep Fragmentation, Choking/gasping during sleep, Shortness of Breath/Dyspnea, Hypoxemia, Witnessed Apnea, Fatigue or Malaise, Sleep Walking/Talking, Nocturia, Nocturnal Leg Movements, PAP compliance problems, Morning Headaches, Inappropriate daytime naps, Cataplexy, Impaired Cognition, Mood Disorder, and Other.

PAST MEDICAL HISTORY:

Table with 5 columns of medical history: Hypertension, COPD, Diabetes, Seizures, Obesity, Stroke, CHF, Atrial Fib, Ischemic Heart Disease, and Other.

Previous Sleep Study: YES NO When: \_\_\_\_\_ Where: \_\_\_\_\_

Currently on CPAP: YES NO How long: \_\_\_\_\_ Pressure: \_\_\_\_\_

IMPRESSION / PRIMARY DX: MUST HAVE AT LEAST ONE PRIMARY DX

Table with 2 columns of diagnosis options: G47.30 Sleep Apnea, G47.33 OSA-witnessed apnea, G47.10 Excessive Daytime Sleepiness, F51.01 Primary Insomnia, G47.36 Hypoxemia, G47.61 Periodic limb movements, G25.81 Restless legs, G47.20 Circadian Rhythm Sleep Disorder, G47.419 Narcolepsy, G47.411 with cataplexy, and Other.

TREATMENT PLAN: I authorize the following tests and evaluations as medically necessary based on the above symptoms and diagnosis.

Table with 3 columns: Test/Evaluation, CPT Code, and Description. Includes options like Evaluate and Treat, Polysomnogram (PSG), CPAP / BiLevel Titration, Follow up Titration Study, Split Night Study, MSLT, PAP Nap, and Consultation with Sleep Specialist.

Special Instructions:

Provider Name: \_\_\_\_\_ NPI: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

OFFICE USE ONLY: MD APPROVAL FOR AASM ACCREDITATION STANDARD C-2-F

STUDY APPROVED: YES NO, Study Ordered: \_\_\_\_\_

COMMENTS: \_\_\_\_\_

MEDICAL DIRECTOR SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_