



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:

<input type="checkbox"/> Loud or Disruptive Snoring (R06.83)	<input type="checkbox"/> Witnessed Apnea (G47.30)	<input type="checkbox"/> Morning Headaches (R51)
<input type="checkbox"/> Excessive Daytime Sleepiness (G47.10)	<input type="checkbox"/> Fatigue or Malaise (R53.83)	<input type="checkbox"/> Inappropriate daytime naps (G47.41)
<input type="checkbox"/> Sleep Fragmentation (F51.8)	<input type="checkbox"/> Sleep <input type="checkbox"/> Walking <input type="checkbox"/> Talking (G47.50)	<input type="checkbox"/> Cataplexy
<input type="checkbox"/> Choking/gasping during sleep	<input type="checkbox"/> Nocturia (R35.1)	<input type="checkbox"/> Impaired Cognition (G31.84)
<input type="checkbox"/> Shortness of Breath/Dyspnea (R06.00)	<input type="checkbox"/> Nocturnal Leg Movements	<input type="checkbox"/> Mood Disorder (F39)
<input type="checkbox"/> Hypoxemia (G47.36)	<input type="checkbox"/> PAP compliance problems (Z91.19)	<input type="checkbox"/> Other:

PAST MEDICAL HISTORY:

<input type="checkbox"/> Hypertension	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Obesity	<input type="checkbox"/> CHF	<input type="checkbox"/> Ischemic Heart Disease
<input type="checkbox"/> COPD	<input type="checkbox"/> Seizures	<input type="checkbox"/> Stroke	<input type="checkbox"/> Atrial Fib	<input type="checkbox"/> Other:
Previous Sleep Study: <input type="checkbox"/> YES <input type="checkbox"/> NO When: _____		Where: _____		
Currently on CPAP: <input type="checkbox"/> YES <input type="checkbox"/> NO How long: _____		Pressure: _____		

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

<input type="checkbox"/> G47.30 Sleep Apnea, unspecified	<input type="checkbox"/> G47.61 Periodic limb movements during sleep
<input type="checkbox"/> G47.33 OSA-witnessed apnea during sleep	<input type="checkbox"/> G25.81 Restless legs while falling asleep
<input type="checkbox"/> G47.10 Excessive Daytime Sleepiness / Hypersomnia	<input type="checkbox"/> G47.20 Circadian Rhythm Sleep Disorder
<input type="checkbox"/> F51.01 Primary Insomnia (include another dx for sleep testing)	<input type="checkbox"/> G47.419 Narcolepsy <input type="checkbox"/> G47.411 with cataplexy
<input type="checkbox"/> G47.36 Hypoxemia	<input type="checkbox"/> Other:

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

<input type="checkbox"/> Evaluate and Treat	CPT 95810, 95811, 95805 and 95807	Polysomnogram, with 2 nd night CPAP Titration, and/or MSLT, and/or PAP Nap, if indicated.
<input type="checkbox"/> Polysomnogram (PSG)	CPT 95810	1 st Night Diagnostic Study for Evaluation only
<input type="checkbox"/> CPAP / BiLevel Titration	CPT 95811	2 nd Night Titration following Diagnostic Study with DX of OSA
<input type="checkbox"/> Follow up Titration Study	CPT 95811	For Patients currently using PAP therapy
<input type="checkbox"/> Split Night Study	CPT 95811	Initial Diagnostic period followed by CPAP initiation for AHI>40
<input type="checkbox"/> MSLT	CPT 95805	Daytime Nap Study for EDS (PSG performed the preceding night)
<input type="checkbox"/> PAP Nap	CPT 95807-52	Daytime abbreviated Cardio-Respiratory Sleep Study to Acclimate Insomnia patients with OSA to PAP therapy
<input type="checkbox"/> Consultation with Sleep Specialist	<input type="checkbox"/> Pre-Study <input type="checkbox"/> Post Study	Evaluation and Management of Patient for Sleep Complaints

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:** _____