



**Sleep Management Services**  
**9305 Treasure Hill Rd Little Rock, AR 72227**  
**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:**

<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:
<b>Previous Sleep Study:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>When:</b> _____ <b>Where:</b> _____				
<b>Currently on CPAP:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>How long:</b> _____ <b>Pressure:</b> _____				

**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 <sup>nd</sup> night CPAP Titration, and/or MSLT, and/or PAP Nap, if indicated.
<input type="checkbox"/> Polysomnogram (PSG)	CPT 95810	1 <sup>st</sup> Night Diagnostic Study for Evaluation only
<input type="checkbox"/> CPAP / BiLevel Titration	CPT 95811	2 <sup>nd</sup> 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:** \_\_\_\_\_