



Sleep Management Services
501 Millwood Circle Ste. F, Maumelle, AR 72113
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: _____ |
| 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 Dr. David Anderson	<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: _____