1028 East Main Street
Morehead, KY 40351

St. Claire
OUTPATIENT CENTER

Phone (606) 783-6866
Fax (606) 783-6910

Sleep Study Order Form

Patient Information (please print)

Patient Name _____ DOB _____ M / F

Address _____ City _____

State _____ Zip _____ Home Phone _____ Cell Phone _____

Insurance 1: _____ ID#: _____ Pre-Cert: _____

Insurance 2: _____ ID#: _____ Pre-Cert: _____

Testing Options

- ❑ **Initial** Nocturnal Polysomnography (CPT 95810), if OSA or CSA is present **split** (CPT 95811) or schedule a titration (CPT 95811)
  - Pediatric under age 6 uses CPT 95782 for Initial and CPT 95783 for Titration
- ❑ **CPAP Titration** / Bi-level / AutoSV Titration/AVAPs (CPT 95811)
- ❑ **Polysomnography** (95810) **with next day Multiple Sleep Latency Test *or*** Maintenance of Wakefulness Test (CPT 95805)
- ❑ **Multiple Sleep Latency Test *or*** Maintenance of Wakefulness Test (CPT 95805)
- ❑ Positive Airway Pressure **(PAP)-Nap** (Daytime Sleep Study) to assess for mask leak and/or pressure tolerance concerns (CPT 95807)
- ❑ Unattended portable monitoring **(Home Sleep Study)** (CPT 95806)

Special Instructions *(Please check all that apply):*

- ❑ Oxygen _____
- ❑ Handicapped Room
- ❑ Adjustable bed
- ❑ Caregiver Presence Needed During Test
- ❑ Translator Needed
- ❑ Immobile
- ❑ Allergies _____
- ❑ Other _____

Please use Nebulizer Protocol (policy # 12-0509-33) ___**Yes** ___**No**
Patient is to self-administer prescribed 10 mg tablet of Ambien or 8 mg tablet of Rozerem upon arrival: ___**Yes** ___**No**
Patient is to self-administer current medications ____**Yes** _____**No**
The patient's medication list has been reviewed and medications to be held prior to/during the sleep study are as noted: _____

Diagnosis

____ Obstructive Sleep Apnea **G47.33**
____ Hypersomnia with Sleep Apnea **G47.10**
____ Periodic Leg Movements in Sleep **G47.61**
____ Snoring **R06.83**
____ Central Sleep Apnea **G47.37**
____ Sleep Apnea, Unspecified **G47.30**
____ Insomnia **G47.0**
____ Other _____
____ Parasomnias **G47.50**
____ Narcolepsy **G47.41**
____ Fatigue, Unspecified **R53.83**

Set up Positive Airway Pressure (PAP) per Sleep Center PAP protocol policy # 12-0510-71 ____**Yes** ____**No**
Schedule follow-up appointment with Sleep Medicine Specialist ___ **Yes** ___ **No**

Signature: _____ **Provider Name:** _____ **MD / DO / APRN / PA**

Date: _____ **NPI:** _____ **Ph:** _____ **Fax:** _____

Office Staff:

Send **recent office visit (with sleep symptom documentation)**, **demographics sheet**, and **this order form** to fax number **606-783-6910** to schedule patient.

Please note *you will be responsible for obtaining insurance prior authorization*, but you should wait to obtain this until after the patient is scheduled so it does not expire prior to the test date.