

1028 East Main Street
Morehead, KY 40351



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):

- | | | |
|-------------------------------------------|----------------------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Oxygen _____ | <input type="checkbox"/> Caregiver Presence Needed During Test | <input type="checkbox"/> Immobile |
| <input type="checkbox"/> Handicapped Room | <input type="checkbox"/> Translator Needed | <input type="checkbox"/> Allergies _____ |
| <input type="checkbox"/> Adjustable bed | | <input type="checkbox"/> 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** ___ Central Sleep Apnea **G47.37** ___ Parasomnias **G47.50**
___ Hypersomnia with Sleep Apnea **G47.10** ___ Sleep Apnea, Unspecified **G47.30** ___ Narcolepsy **G47.41**
___ Periodic Leg Movements in Sleep **G47.61** ___ Insomnia **G47.0** ___ Fatigue, Unspecified **R53.83**
___ Snoring **R06.83** ___ Other _____

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.