PHYSICIAN PRESCRIPTION FOR SLEEP TESTING

☐LAWRENCEBURG ☐MARSHALL MEDICAL ☐MAURY REGIONAL ☐WAYNE MEDICAL

PATIENT NAME _____

SSN _____ **D.O.B.** _____ **PRIMARY CARE PHYSICIAN** _____

PRIMARY PHONE # _____ **ALT. PHONE #** _____

MALE _____ **FEMALE**_____ **HEIGHT** _____ **WEIGHT** _____

Please include patient's current medical history, insurance card, and most recent history and physical.

(Sleep Center Medical Director will review Test Order for medical necessity to ensure symptoms warrant testing.)

*****A valid Test Order and recent H&P (detailing pt's sleep symptoms) is required to schedule a sleep study*****

Include ALL symptoms that warrant testing. Patient must have a sleep complaint with appropriate symptoms:

PRIMARY SLEEP SYMPTOMS (CHECK ALL THAT APPLY):

☐ Hypersomnia, EDS G47.10 ☐ Hypersomnia w/long sleep time G47.11 ☐ Hypersomnia w/o long sleep time G47.12
☐ Snoring R06.83 ☐ Unexplained morning headaches G44.89 ☐ Sleep Terrors F51.4 ☐ Restless sleep G47.8
☐ Obstructive Sleep Apnea G47.33 ☐ REM Behavior Disorder G47.52 ☐ Sleep related hypoventilation G47.36
☐ Sleep Apnea, unspecified G47.30 ☐ Periodic Limb Mvmt Disorder G47.61 ☐ Primary central sleep apnea G47.31

CONTRIBUTING SYMPTOMS (CHECK ALL THAT APPLY):

☐ Insomnia G47.00 ☐ Cognitive impairment G31.84 ☐ COPD J44.9 ☐ CHF I50.9 ☐ Restless Legs G25.81
☐ Stroke Z86.73 ☐ Atrial Fibrillation I48.91 ☐ Hypertension I10 ☐ Obesity E66.9
☐ Depression F32.89 ☐ Diabetes E11.9 ☐ Other (include ICD-10 code):_____

SPECIAL NEEDS: Pts who are in a nursing home or need any type of nursing care are required to bring someone to assist them. We do not provide or administer medications. Pts who exhibit signs of having a medical emergency will be evaluated by appropriate medical personnel and may be taken to the ER.

☐ Supplemental O2 @ ___l/m (O2 will not be used during study unless O2 protocol is met)
☐ Wheelchair ☐Blind ☐Needs Hospital bed/specialty bed ☐Language barrier
☐Other Instructions: _____

☐ *****Check here if you will provide results and any required follow up care to your patient*****

(To ensure patients receive results and any required follow up care, they will follow up with the Sleep Specialist unless the above is checked.)

TEST NEEDED: (A Home Sleep Test will be performed in place of a Polysomnogram if mandated by patient's insurance company)

☐ Complete Sleep Testing (Polysomnogram cpt 95810/95782; CPAP Titration cpt 95811/95783 if positive for OSA on next visit)
☐ Polysomnogram ages 6 and up, cpt 95810; ages 2-5, cpt 95782
☐ Split Night Study cpt 95810/95782 or cpt 95811/95783 (pt may be titrated on night one, if lab protocol is met)
☐ CPAP Titration ages 6 and up, cpt 95811; ages 2-5, cpt 95783
☐ BiLevel, ST, ASV, or iVAPS Titration (circle desired therapy) ages 6 and up, cpt 95811; ages 2-5, cpt 95783
☐ MSLT cpt 95805 (Must also check Polysomnogram above) (If pt is on CPAP, enter current settings: _____cmH20)
☐ MWT cpt 95805 (Must also check Polysomnogram above)
☐ Home Sleep Test Portable Monitor cpt 95800 (☐ Schedule CPAP Titration (cpt 95811), if positive for OSA, on next visit)

(*all above referenced cpt codes are current as of March 2022 and are subject to change*)

Letter of Medical Necessity

The symptoms listed above are consistent with the presence of obstructive sleep apnea syndrome, a life threatening disorder. These findings warrant the medical necessity of overnight polysomnographic and oximetric evaluation of this patient to assess the presence of a severity of sleep apnea.

Signature _____ Date _____ Time _____

Print physician's name _____ NPI # _____

Phone # _____ Fax # _____

FAX Completed Form to: (931) 490-3915. For scheduling questions, please call: (931) 380-4044.

(This form will be returned to your office if scheduling is unable to contact the patient after 3 consecutive business days)

☐ **Notify physician of patient's appointment date.**