SLEEP SERVICE REQUEST

PLEASE COMPLETE LOWER PORTION AND FAX TO 619-754-2204

Patient Name:_____ **Date of Birth:** _____ **Gender:** _____

Patient Phone: _____ **Insurance:** _____

Indication/Suspected Diagnostic

- ❑ Suspected Sleep Apnea/Breathing Pauses/Habitual Choking/Gasping during sleep (G47.30)
- ❑ Obstructive Sleep Apnea (G47.33)
- ❑ Night Sweats (L74.9)
- ❑ Snoring (R06.83)
- ❑ Hypertension (I10)
- ❑ Excessive Day me Sleepiness/Hypersomnia (G47.10)
- ❑ Obesity/Significant Weight Loss/Gain (E66.01)
- ❑ Excessive/Abnormal Body/Limb Movement (G47.61)
- ❑ Abnormal Sleep Behaviors - Violent/Injurious (F51.8)
- ❑ Narcolepsy (G47.419)
- ❑ AHI _____ RDI _____ Lowest O2 _____

Type Of Testing Required

❑ **Polysomnography (PSG):** Full-night, in-lab sleep study a ended by a technologist (CPT: 95810)

❑ **Split PSG:** PSG with possible PAP titration if patient meets diagnostic and procedural criteria (CPT: 95811)

❑ **CPAP/BiPAP/ASV Titration:** PSG with PAP, O_2, or oral appliance titration. Please attach previous diagnostic sleep study (CPT: 95811)

❑ **Positive Airway Pressure (PAP) Nap:** A daytime study to ensure a patient tolerates the CPAP mask (CPT: 95807)

❑ **SARS-CoV-2 RNA, Qualitative Real-Time RT-PCR (nasal swab)**: COVID-19 testing required for all PAP studies.

❑ **Home Sleep Test (HST):** At home sleep study primarily to diagnose obstructive sleep apnea (CPT: 95806)

❑ **Multiple Sleep Latency Test (MSLT)/Multiple Wakefulness Test (MWT):** Used to rule out narcolepsy. Note: if patient meets diagnostic and procedural protocol, PAP titration will be performed and MSLT will be cancelled (CPT 95810 and 95811/95805)

❑ **Treatment Authorization:** Sleep Medicine Physician to prescribe and manage appropriate treatment for patient.

❑ **Notes/Special Requests:** _____

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Physician: _____ NPI #: _____

Phys. Phone Number: _____ Fax: _____

Phys. Signature: _____ Date: _____

FAX ORDER FORM BACK TO 619-754-2204

PLEASE INCLUDE PATIENT CLINICAL INFORMATION AND INSURANCE CARD

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