



# SLEEP DIAGNOSTICS

**Chico**

Ph: 899-8853  
Fax: 899-8854

**Oroville**

Ph: 589-7864  
Fax: 589-7868

**Paradise**

Ph: 877-1871  
Fax: 877-1891

## Sleep Study Physician Order

Patient Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Other Phone: \_\_\_\_\_

**Study Ordered:**

- Diagnostic Sleep Study (PSG) – 95810**  
**CPAP Titration Study if positive for sleep apnea – 95811**
- Split Night Sleep Study – 95811**
- Diagnostic Sleep Study (PSG) – 95810**
- CPAP / BIPAP / ASV Titration Study – 95811**
- Diagnostic Sleep Study (PSG) – 95810, followed by**  
**Multiple Sleep Latency Test (MSLT) – 95805**
- Overnight Screening Pulse Oximetry**

Special Instructions / DME: \_\_\_\_\_

**For Medical Necessity:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Sleep Apnea   | <input type="checkbox"/> Excessive Daytime Sleepiness | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Narcolepsy    | <input type="checkbox"/> Insomnia                     | <input type="checkbox"/> Impaired Cognition  |
| <input type="checkbox"/> Mood Disorder | <input type="checkbox"/> Depression                   | <input type="checkbox"/> History of Stroke   |
| <input type="checkbox"/> CHF           | <input type="checkbox"/> Cardiac Arrhythmia           | <input type="checkbox"/> Heart Disease       |

Other Diagnosis: \_\_\_\_\_

\_\_\_\_\_  
Physician Signature M.D./ D.O. Office Phone: \_\_\_\_\_

\_\_\_\_\_  
(Print name) M.D./ D.O. Office Fax: \_\_\_\_\_

Office Contact Name: \_\_\_\_\_

Sleep Diagnostics will obtain insurance authorization and schedule the patient.

**FAX THIS FORM WITH THE FOLLOWING INFORMATION:**

- 1. Copy (front & back) of insurance card**
- 2. Patient demographic information**
- 3. Clinical notes relating to sleep disorder**