



Sleep Study Physician Order

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**

FAX TO: 530.674.2441

Patient Name: _____ Home Phone: _____

DOB: _____ Sex: _____ BP: _____ Work Phone: _____

Height: _____ Weight: _____ Neck Circ.: _____ 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

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.

If you have any questions please call 530.674.2328