SLEEP DIAGNOSTICS OF FREMONT
556 Mowry Ave, Suite 102, Fremont, CA 94536
Phone: 800-961-9711 / 510-742-5432

Please complete and FAX to: 510-742-8767

SLEEP EVALUATION REQUEST and CERTIFICATE OF MEDICAL NECESSITY

Patient Name: FIRST_____MI_____LAST_____

Date of Birth: _____/_____/_____ Patient Phone: _____

NOTE: Per government and accrediting organizations' requirements. "History and physical" information from the ordering physician record is required. Please enclose patient insurance information and chart copies as appropriate with your order. Entering patient symptoms and current diagnoses on the last portion of this form may substitute for office notes if signed by the physician. Telephone or fax any additional requests regarding your patient.

ORDERING A SLEEP STUDY

{CHECK ONE ORDER THAT APPLIES}

_____**Polysomnography with CPAP titration (Split PSG if indicated or dedicated CPAP titration PSG follow up test)**
CPAP is initiated after a period of baseline recording, indicating the patient meets split night CPAP initiation protocol requirements. NOTE: Intervention protocols with CPAP or O_2 may begin if a patient reaches criteria identified as diagnostic by medical director.

Patient currently on oxygen? No___ If yes, list level: _____ Study to begin on oxygen? No___ If yes, list level: _____

_____**Split PSG if indicated / Multiple Sleep Latency Test (MSLT) if indicated**
MSLT ordered with over-night PSG, MSLT will only be performed if there is no indication of obstructive sleep apnea (OSA).

_____**PSG only (Polysomnography only)** Do not titrate CPAP.

_____**CPAP titration PSG** Study began on CPAP and is titrated.

_____**BiLevel Pressure titration** Specify pressure to start: _____cmH_20 inspiratory, _____cmH_20 expiratory

_____**PSG / MSLT** _____**PSG / MWT** ____**MSLT only** _____**MWT only**

*_____**AMA Impairment Study to Include PSG with MSLT.** Study will include reports on Sleep Impairment and an AMA Impairment Report using 5th Edition AMA Guides. No Titration will be performed. Studies will be performed in sequence over 20 hours. PSG Diagnostics Test with Report for Impairment will be billed with codes: 95810/99199/99090/99052/99070/99080. MSLT Alertness Test with Report for Impairment will be billed with codes: 95805/99199/99090/99070/99080

PRELIMINARY DIAGNOSIS CODES

_____Hypersomnia with sleep apnea (ICD-9-CM 780.53) Other:_____

Clinical Information

Height:_____inches Weight:_____lbs. Gender: M F

Clinical presentation / symptoms for which study is ordered (ex. excessive sleepiness, snoring, witnessed apnea):
Copy of office record can be used for this purpose.

_____

_____

Existing physical conditions / diseases:_____

_____

_____ Instructions: • Oxygen to be titrated as needed • Patient to bring own medication for self-administration

Other instructions / special instructions regarding study:_____

ORDERING PHYSICIAN INFORMATION

Physician Name:_____ Office Contact Person:_____

Physician Address:_____

Phone:_____ Fax:_____ UPIN#:_____

PHYSICIAN SIGNATURE: _____

I certify that to the best of my knowledge, this test and any interpretation is necessary in order to provide information which will assist in the proper diagnosis and/or treatment for the above named patient.

PLEASE FAX INSURANCE CARD AND BIO-DATA INFORMATION WITH THIS, AS IT WILL EXPEDITE SCHEDULING.

FOR WORKERS COMPENSATION CASES PLEASE INCLUDE A PROGRESS REPORT, AUTHORIZATION LETTER, ETC.