SLEEP DIAGNOSTICS OF FREMONT

556 Mowry Avenue, Suite 102, Fremont, CA 94536
Main: (510) 742-5432 Fax: (510) 742-8767

SLEEP EVALUATION REQUEST

Patient Name: FIRST_____MI_____LAST_____

Date of Birth: _____/_____/_____ Phone: (H)_____(W)_____(C)_____

{CHECK ALL ORDERS THAT APPLY}

_____ **Consult/Management -** Consult with a Board Certified Sleep Specialist to evaluate and manage sleep issues prior to and/or post test(s).

_____ **Comprehensive Polysomnography** – Gold Standard Diagnostic sleep study and if positive for apnea/hypopnea, followed by CPAP titration study. If the patient has enough respiratory events in first part of study, they may qualify for a **Split Night** study

_____ **Diagnostic Polysomnography only** [Do not titrate CPAP.]

_____ **CPAP/Bi-Level PAP/ASV Titration Polysomnogram** [Study begins on CPAP (unless otherwise indicated), if failure try BiPAP or ASV.]

_____ **Multiple Sleep Latency Test (MSLT)/Maintenance of Wakefulness Test (MWT)** [Daytime Nap Studies]

_____ **AMA Impairment Study to Include PSG with MSLT.** [Study includes AMA Impairment Report using 5th Edition AMA Guides.]

_____ **Home Sleep Test** Type II diagnostic home sleep study to evaluate for sleep disordered breathing

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PLEASE FAX THIS FORM TO (510) 742-8767 WITH THE FOLLOWING INFORMATION:

1. **Copy of insurance card**
2. **Patient demographic information**
3. **Clinical notes related to sleep issues**

PRELIMINARY DIAGNOSIS CODES

_____Sleep Apnea/Sleep Related Breathing Disorder, Unspecified (ICD-9-CM 327.20)

_____Obstructive Sleep Apnea (ICD-9-CM 327.23) Other:_____

Clinical presentation/symptoms/existing illnesses (notation not needed if clinical notes faxed):

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_____ Patient to self-administer own medicine OR offer patient Lunesta 3mg (or Lunesta 2mg if age > 65) to self-administer if unable to initiate sleep within 45 min after lights out _____Oxygen to be titrated as needed

Other special instructions regarding study:_____

ORDERING PHYSICIAN INFORMATION

Physician Name:_____ Office Contact Person:_____

Phone:_____ Fax:_____

PHYSICIAN SIGNATURE: _____

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