SLEEP SERVICE REQUEST

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

Patient Phone: _____ **Insurance:** _____

Indication/Suspected Diagnostic

- ❑ Observed Apnea/Breathing Pauses (G47.33)
- ❑ Narcolepsy (G47.429)
- ❑ Habitual Choking/Gasping/Night Sweats (G47.30)
- ❑ Hypertension (I10)
- ❑ Excessive Daytime Sleepiness/Hypersomnia (G47.10)
- ❑ Snoring (G47.8)
- ❑ Obesity/Significant Weight Loss/Gain (E66.01)
- ❑ Excessive/Abnormal Body/Limb Movement (G47.61)
- ❑ Abnormal Sleep Behaviors - Violent/Injurious (F51.8)

Type Of Testing Required

- ❑ **Polysomnography (PSG):** Full-night, in-lab sleep study attended 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)
- ❑ **CPAP/BiPAP/ASV Titration w/ Sleep Consult/Evaluation:** Titration and evaluation by Certified Sleep Physician to determine and order appropriate therapies. Please attach previous diagnostic sleep study (CPT: 95811 and 99242/99244/99213/99215)
- ❑ **Home Sleep Test (HST):** Diagnostic 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

Phone: 619-717-8102 | Administration@AmeriSleepSD.com | AmeriSleepSD.com

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