



# SLEEPNOSTICS SLEEP CENTERS

Improving the Quality of Life Through Sleep Science

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## PHYSICIAN ORDER FORM

Patient Name: _____	Date: _____
DOB: _____	SSN: _____
Phone: (Hm) _____	(Wk) _____ (Cell) _____

### Please choose one of the following procedures:

- Diagnostic Sleep Study (PSG) 95810 (Night 1)  
CPAP Titration Study 95811 (Night 2, if positive for sleep apnea)
- Split Night Study (Nasal CPAP is applied if patient meets RDI of 20 after 2 hr baseline is achieved)
- Diagnostic Sleep Study (PSG) 95810 (Nocturnal Polysomnogram)
- CPAP Titration Study 95811 (Nasal CPAP is titrated until apneic events are resolved, Diagnostic Sleep Study 95810 needed prior to this study)
- Multiple Sleep Latency Test (MSLT) 95805 (Daytime Study)

Check this box if you would like a Consult with a Staff Sleep / ENT Specialist

### Diagnosis:

- |   |  |
|---|--|
| <input type="checkbox"/> Loud Snoring                       | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Witnessed Apneas                   | <input type="checkbox"/> Obesity             |
| <input type="checkbox"/> Daytime Sleepiness                 | <input type="checkbox"/> COPD / Asthma       |
| <input type="checkbox"/> Leg Twitching                      | <input type="checkbox"/> Morning Headaches   |
| <input type="checkbox"/> Nasal Congestion / Deviated Septum | <input type="checkbox"/> Restless Sleeper    |
| <input type="checkbox"/> Frequent Awakenings                | <input type="checkbox"/> Other _____         |

Physician Name: _____	NPI: _____
Phone: _____	Fax: _____
Physician's Signature: _____	

**PLEASE FAX <sup>1.)</sup> THIS FORM, <sup>2.)</sup> FRONT & BACK OF INSURANCE CARD, AND <sup>3.)</sup> PATIENT FACE SHEET**