

Patient Information (Required for Scheduling)

Patient Name: _____ DOB: _____ Sex: M F SS#: XXX-XX-_____
First & Last Name

Patient's Address: _____ Street _____ City _____ State _____ Zip Code _____

Home Phone#: _____ Mobile Phone #: _____ Email Address: _____

Primary Insurance: _____ Policy #: _____ Group #: _____ Phone #: _____
Plan & Product

Secondary Insurance: _____ Policy #: _____ Group #: _____ Phone #: _____
Plan & Product

Order Information - Sleep Disorder Center

Presenting Symptoms:

- | | | |
|---|--|-------------------------------|
| <input type="checkbox"/> Loud snoring | <input type="checkbox"/> Non-restorative sleep | Other (please specify): _____ |
| <input type="checkbox"/> Observed apnea | <input type="checkbox"/> Limb restlessness/jerks | |
| <input type="checkbox"/> Excessive daytime sleepiness | <input type="checkbox"/> Sleep paralysis or cataplexy | |
| <input type="checkbox"/> Difficulty initiating sleep | <input type="checkbox"/> Early AM awakening | |
| <input type="checkbox"/> Difficulty maintaining sleep | <input type="checkbox"/> Hypnagogic/Hypnapompic hallucinations | |

Risk Factors: Hypertension Stroke Myocardial Infarction CHF

Current Medications (please list or attach): _____

Allergies (please list) _____

Physician exam (please attach clinic note and patient demographics)

_____ Height _____ Weight _____ BMI _____ Obesity _____ Epworth _____

Suspected Diagnoses (check at least one):

- Obstructive Sleep Apnea (327.23)
 Complex/Central Sleep Apnea (327.21)
 Narcolepsy (347)
 Parasomnia (please check) Limb movements (327.51) Sleepwalking (307.46) Seizure (345.10)
 Insomnia (780.52)
 Other (please specify): _____

ICD-CM Diagnosis Codes for each diagnosis: _____

Test(s) Requested:

- Polysomnography (95810)
 C/Bi/ASV Titration (95811)
 Split night (95811)
 Home Sleep Test (95806)
 MWT (95805)

Special requirements:

- Video Begin O₂ pre study
 Additional EEG If SAO₂ is less than 85%
 May use O₂ up to 5 lpm to maintain greater than 90% saturation
 Three Night Premium Home Testing Service
 MSLT (95805)

Follow-up Options: (A copy of all results will be sent to the referring physician)

- Perform the CPAP/Bi-Level titration if polysomnogram demonstrates sleep apnea
 Referring Doctor will counsel patient and order further studies or treatment as needed
 Consult the interpreting physician for patient's management
 Sleep Center to arrange for CPAP/BiPAP therapy

Referring Physician Information

Physician Name (first & last): _____ NPI#: _____ GA License#: _____

Physician Address: _____ Phone#: _____ Fax #: _____

I hereby certify that the services in the above order form are medically necessary.

Physician Signature: _____ Date: _____ Time: _____



DeKalb Medical

FAX Orders to: 404.501.7088
Phone: 404.501.5927



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**SLEEP DISORDER CENTER
ORDER FORM**

DMC FORM # PS-1058 (10/31/14)