Beth Israel Deaconess Hospital
Milton

EXPEDITE

Sleep Testing oneForm Request

please fax completed form with most recent office notes to: 617-796-9099
For questions, please call: 617-796-7766

DEMOGRAPHIC INFORMATION

Patient Name:_____DOB:_____ English Proficient? □ Yes □ No

Patient Phone Numbers: Mobile #: _____ Home#: _____ Alternate #: _____

Insurance Provider:_____Insurance ID #: _____

SLEEP STUDY REQUESTED

☐ **Polysomnography (95810):** All night attended diagnostic sleep study (PSG) to evaluate for all sleep disorders.

☐ **Split Night (95811)":** Attended diagnostic testing including CPAP initiation & titration. If titration criteria met with less than three hours testing remaining, a new order for an all-night PAP titration study will be required. Refer to interpretation report.

☐ **PAP Titration*** **(95811**): Titrate positive airway pressure to optimal pressure level.
OSA must be previously documented by a PSG.* **Date of PSG:_____

☐ **Home Sleep Apnea Test (HSAT) :** Unattended Type 3 diagnostic testing. Recommended ONLY for patients with high likelihood of Obstructive Sleep Apnea (OSA). Provider: Neurocare, Inc. (TIN: 043032581)

If the in-lab study is not approved and a Home Sleep Test is offered, I authorize the HST as a substitution unless "NO" is selected □ *NO*

SPECIAL NEEDS/ASSISTANCE *(please specify)*

☐ Supplemental Oxygen *(if selected, HSAT cannot be performed)*

INDICATION *(suspected sleep disorder)*

☐ Obstructive Sleep Apnea (G47.33)
☐ Central Sleep Apnea (G47.31)
☐ Narcolepsy (G47.419)
☐ REM Behavior Disorder (G47.52)
☐ Periodic Limb Movements (G47.61)
☐ Other: _____

PATIENT COMPLAINTS *(select at least one)*

☐ Excessive daytime sleepiness
☐ Disruptive snoring
☐ Frequent arousals/disturbed or restless sleep
☐ Not refreshed or rested after sleeping

SYMPTOMS *(select at least two)*

☐ Witnessed apneas
☐ Waking up gasping/choking
☐ Decreased concentration
☐ Memory Loss
☐ Enlarged tonsils/physiological abnormalities compromising respiration
☐ Leg/arm jerking
☐ Bruxism/teeth grinding during sleep
☐ Nocturia
☐ Decreased libido
☐ Hypertension
☐ Irritability
☐ Other:

***Duration of Symptoms:**
□ < 2 months □ > 6 months
□ > 2 months □ > 1 year

DOCUMENTED COMORBIDITIES & MEDICAL HISTORY

☐ Critical illness or physical impairments preventing use of portable HST device
☐ Moderate to severe Congestive Heart Failure
☐ History of Myocardial infarction (s/p 3 mo.)
☐ History of stroke (Date: _____)
☐ Neuromuscular weakness affecting respiratory function
or impairing activity (please specify: _____)
☐ Moderate to severe pulmonary disease
☐ Patient prescribed opiates: _____
☐ Polycythemia
☐ Other: _____

I acknowledge that the clinical information submitted to support this request is accurate and specific to this patient, and all information has been provided. I authorize submission of this information for precertification on my behalf.

Ordering Provider Signature:_____Date: _____

Print Name:_____NPI: _____